NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

Congressional Information Service, Inc
4520 East-West Highway
Bethesda, Maryland 20814

CIS

102d Congress
1st Session

COMMITTEE PRINT

WMCP:
102-9

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

OVERVIEW OF ENTITLEMENT PROGRAMS

1991 GREEN BOOK

BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

MAY 7, 1991

Prepared for the use of Members of the Committee on Ways and Means by members of its staff. This document has not been officially approved by the Committee and may not reflect the views of its Members

U.S. GOVERNMENT PRINTING OFFICE
39-759 WASHINGTON : 1991

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

H782-12

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

DAN ROSTENKOWSKI, ILLINOIS, *Chairman*

ROBERT J. LEONARD, *Chief Counsel and Staff Director*

This document was prepared by the majority staff of the Committee on Ways and Means and is issued under the authority of Chairman Dan Rostenkowski. This document has not been reviewed or officially approved by the Members of the Committee.

LETTER OF TRANSMITTAL

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC, May 7, 1991.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Upon your election as Chairman of the Committee on Ways and Means in 1981, you instructed the staff to prepare a resource document on programs within the Committee's legislative jurisdiction. That year and annually since, the Committee has published the "Green Book," which presents background material and statistical data on the major entitlement programs within the Committee's jurisdiction: Social Security, Medicare, trade adjustment assistance, unemployment compensation, Aid to Families with Dependent Children, child support enforcement, Supplemental Security Income, the Title XX social services block grant program, child welfare, foster care, and adoption assistance.

While initially intended for the use of the Members of the Committee and their staffs, this document has become a valuable resource for Members of Congress, Congressional staff, government officials at the Federal, State and local level, academicians, public policy analysts, as well as the general public.

On behalf of the staff, I am pleased to transmit to you and the other Members of the Committee on Ways and Means, the 1991 edition (the 11th edition) of the Green Book. The Green Book integrates a description of each program within the jurisdiction of the Committee with current data regarding the population served by the program, an analysis of interactions with other major programs, and historical background information.

The staff wishes to express its appreciation to the many individuals and organizations who contribute annually to the publication of the Green Book. The following organizations and individuals deserve to be recognized for their contributions:

1. The Congressional Research Service of the Library of Congress;
2. The Congressional Budget Office;
3. The Office of Research and Statistics of the Social Security Administration;
4. The Office of the Actuary of the Social Security Administration;
5. The Health Care Financing Administration of the Department of Health and Human Services;
6. The Prospective Payment Assessment Commission;

7. The Physician Payment Review Commission;
8. The Department of Labor;
9. The Office of Family Assistance and the Office of Child Support Enforcement of the Department of Health and Human Services;
10. The Census Bureau;
11. The Pension Benefit Guaranty Corporation;
12. The staff of the Railroad Retirement Board;
13. The staff of the Joint Committee on Taxation;
14. The General Accounting Office;
15. The staff of the House Budget Committee;
16. Greg Duncan and Debbie Laren of the Institute for Social Research, University of Michigan;
17. Sheldon Danziger of the Institute of Public Policy Studies, University of Michigan; and
18. Timothy M. Smeeding of the Maxwell School of Citizenship, Syracuse University.

Many members of the Committee's majority staff made a major contribution to the preparation and publication of this document. Seven members of the majority staff deserve special recognition: Wendell Primus, who has coordinated publication of the Green Book for the eleventh consecutive year, Yvette Chocolaad and Rich Hobbie of the Human Resources Subcommittee staff, Kathryn Olson of the Social Security Subcommittee staff, Wendy Taylor, Susan Goldenson, and Ralph Birch.

Any suggestions on how to improve this document as a resource tool are always welcomed and will be reflected in subsequent editions of this publication.

Sincerely,

ROBERT J. LEONARD,
Chief Counsel and Staff Director.

PREFACE

The staff of the Committee on Ways and Means, with assistance from many individuals at the Congressional Research Service, the Congressional Budget Office, the Social Security Administration, the Health Care Financing Administration, the Department of Health and Human Services, the Prospective Payment Assessment Commission, the Physician Payment Review Commission, the General Accounting Office, the Department of Labor, the Census Bureau of the Department of Commerce, the Railroad Retirement Board, and the Joint Committee on Taxation, has prepared this document for the members of the committee to use in evaluating the programs under the committee's jurisdiction, and analyzing possible revisions to such programs.

This document is divided into three parts:

Part 1 describes programs within the jurisdiction of the committee. This part presents summary tables indicating the relative size and recent growth of the individual programs, and extensive information on program eligibility, payment, financing, participant characteristics, interactions with other programs, and history.

Also included in part 1 are 16 appendices which provide background data on topics indirectly related to these programs. The appendices include: a statistical history of the Social Security programs; health status, utilization, and expenditures of the elderly; national health expenditures and health insurance coverage; Medicare reimbursement to hospitals and physicians; data on unemployment, employment, and the labor force; demographic and economic characteristics of families with children and the elderly; poverty, income, and tax burden distributions; wealth statistics; income and population data by State; a description of quality control systems; and descriptions of major social programs not within the committee's jurisdiction.

Part 2 describes four trust funds over which the committee has revenue jurisdiction which provide benefits to individuals. This part presents a brief legislative history of the trust funds, the current financing mechanism of the funds, and the financial status of the funds.

Part 3 presents budget tables, a description of the fiscal year 1991 administration budget outlay proposals, and a description of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. This part also includes two appendices which present excerpts from the Congressional Budget Act and the Committee on Ways and Means' report to the Budget Committee.

The material in this document has been assembled expeditiously in order that it be available to members of the committee for their use in connection with presently pending budget and program issues. Constructive comments regarding the format and content of this document are appreciated.

CONTENTS

Page

Letter of transmittal III
Preface V

PART 1. DESCRIPTION OF PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS PROVIDING BENEFITS OR SERVICES TO INDIVIDUALS

Section 1. The old-age and survivors insurance program (OASI) 3
General 3
Benefits 4
Benefit eligibility: Insured status 6
Benefit computation 8
Benefit amounts 13
Replacement rates 14
Benefit reduction and increase 15
Benefits for recipients of pensions from noncovered employment 22
Automatic benefit adjustments 23
Taxation of Social Security (OASDI) benefits for higher income persons 26
Legislative changes made in the 97th Congress 29
Legislative changes made in the 98th Congress 29
Legislative changes made in the 99th Congress 32
Legislative changes made in the 100th Congress 33
Legislative changes made in the 101st Congress 34
Characteristics of beneficiary population 38

Section 2. Disability insurance program 48
General 48
Benefits 48
Benefit computation 50
Determination of disability 52
Vocational rehabilitation 56
Disability claims and appeals structure 57
Recent experience in the disability program 62
Characteristics of DI beneficiaries 63
GAO study of terminated beneficiaries: 1981–84 65
Legislative changes, 1984–90 67

Section 3. Social Security financing 74
Overview 74
Current law financing 74
Current short-range status of the trust funds 79

Page
New procedures to protect the trust funds 85
The impact of the OASDI surpluses on financial condition of the government 86
Long range status of the trust funds 91
Economic and demographic assumptions 99
Sensitivity of long-term projections 101

Appendix A. Statistical history and future benefit projections of the Social Security programs 105
Coverage 105
Benefits 110
Financing 124
Administrative costs 128

Section 4. Medicare 129
Eligibility 129
Number of beneficiaries 129
Coverage 136
Benefits 136
Administration 137
End stage renal disease program 140
Home health 149
Hospice care 151
Skilled nursing facility 152
Durable medical equipment 154
Medicare payments for services in hospital outpatient departments 161
Utilization and quality control peer review program 165
CBO baseline Medicare projections 166
Medicare as secondary payer 170
Financing 171
Financial status of the trust funds 174
Medicare historical data 179
Recent legislative changes 204
Omnibus Budget Reconciliation Act of 1990 212
Reports and studies 233

Appendix B. Health status, insurance and expenditures of the elderly, and background data on long-term care 241
Health status 241
Causes of death for the elderly 245
Medicare reimbursement and out-of-pocket liabilities of the elderly 247
Analyzing trends in Medicare spending, 1967–96 250
Total health care expenditures for the elderly 254
Background data on long-term care 256

Appendix C. National and international health care expenditures and health insurance coverage 283
National health expenditures 283
Expenditures for hospital care 289
Trends in hospital utilization 293
Expenditures for physicians' services 296
Supply of hospital beds and physicians 305
Health insurance coverage 307

Page
The uninsured and uncompensated care 317
International health spending 321

Appendix D. Medicare reimbursement to hospitals 323
General summary 323
Basic payment system 324
Transition period 325
Update factors 325
DRG weighting factors 327
Source and calculation of the hospital wage index 327
Sample payment calculation 330
Additional payment amounts 332
Indirect medical education costs 332
Disproportionate share hospitals 333
Direct medical education costs 334
ESRD beneficiary discharges 335
Outliers 336
Payments on a reasonable cost basis 339
Capital-related costs 339
Physicians in teaching hospitals 342
Kidney acquisition costs 343
Passthrough payments for hemophilia inpatients 343
Bad debts of Medicare beneficiaries 344
Special treatment of certain facilities 344
Sole community hospitals 344
Medicare dependent hospitals 345
Referral centers 345
Hospitals in rural counties treated as urban counties 346
Section 602k hospitals 347
Hospitals excluded from the prospective payment system 347
Administration 349
Prospective Payment Assessment Commission 349
Administrative and judicial review 350
Review activities 350
Historical trends in PPS payments and hospital Medicare cost, revenue, and utilization 350
Trends in PPS costs, revenue, and margins 350
Margins by hospital type 352
Distribution of PPS hospitals, cases, and payments.... 354
Medicare passthrough payments 354
Effects of policy changes on PPS payments 358
Additional hospital data 363
Estimated effects on PPS hospitals 365
Highlights of legislation and regulations affecting the prospective payment system 365
Increases in Medicare payments to hospitals 366
Wage index 368
Referral centers 370
Outliers 371
Payment for indirect medical education 372
Disproportionate share hospitals 374
Urban/rural boundaries 375
Payments for capital-related costs 376
Additional sources of information 377

Page
Appendix E. Medicare reimbursement to physicians 402
Current payment rules 402
Physician payment reform 405
Effects of physician payment reform 410
Other provisions regarding physician payments 411
Payments for anesthesiology services 414
Payments for radiology services 416
Payments for pathology services 418
Clinical laboratory services 418
Payments for purchased services 420
Assignment rate experience 420
Participating physician program data 424
Participation, assignment, and reasonable charge reductions 429
Distribution of physician services 436
Recent legislation 446

Section 5. Trade adjustment assistance 452
Trade adjustment assistance program for workers 453
Trade adjustment assistance program for firms 461
Most recent major legislative changes 463

Section 6. Unemployment compensation 465
Overview 465
Financing 467
The unemployment trust fund 467
Administrative financing and allocation 479
Benefits 481
Extended benefits 493
Benefit exhaustion 495
Supplemental benefits 499
Hypothetical weekly benefit amounts for various workers in the regular State programs 501
Recent major legislation 503

Appendix F. Statistical data on unemployment, employment and earnings, and the unemployment compensation program 505
Unemployment data 507
Family incomes of unemployment insurance recipients 512
Employment and labor force projections 517
Displaced workers 523
Measures of average earnings or compensations 550
Low wage earnings 560
The Federal minimum wage 561

Section 7. Aid to families with dependent children (title IV-A) 566
Background and eligibility 566
Treatment of income and resources 567
Monthly reporting and retrospective budgeting 570
AFDC benefits under the unemployed parents program 570

Page

Job opportunities and basic skills (JOBS) training program and supportive services:
  - Purpose and administration 572
  - Assessment, employability plan, case management and orientation 572
  - Services and activities 573
  - Participation requirements 575
  - Targeting of JOBS funds 576
  - Supportive and transitional services 581

Interaction between AFDC and other programs 588
AFDC emergency assistance 592
Child care for families at risk of AFDC receipt 595
AFDC benefit levels and trends 595
Federal and State funding of AFDC benefit payments, JOBS and supportive services 608
AFDC caseload data 616
Characteristics of AFDC families 621
Length of time on welfare and turnover within the AFDC caseload 640
Welfare and other sources of support for adolescent mothers 645
The Family Support Act of 1988 649
The 1987 amendments 652
The 1984 amendments 652
Impact of 1981 program changes 656

Section 8. Child Support Enforcement program 656

Background 658
Program trends 658
Demographic trends 659
The process of child support enforcement 663
Services for AFDC and non-AFDC cases 670
The Federal role 670
Federal enforcement tools 672
The State role 673
Enforcement of medical support 674
Wage withholding 678
Property liens 679
Credit bureau reporting 680
Federal garnishment 681
Military allotments 681
Interstate enforcement 681
Summary information on collection techniques 685
Bankruptcy and child support enforcement 686
Linkage between AFDC and child support enforcement 686
Funding 687
Incentive payments to States 687
Payments to AFDC families 689
Payments to non-AFDC families 690
Arrearages 691
Distribution of collections 691
Use of support collections 692
Extent to which Federal Government bears cost of the child support enforcement program 692

Page
Role of automated systems 698
Impact of child support enforcement on AFDC and poverty status 699
Legislative changes in the 101st Congress 721
Legislative changes in the 100th Congress 721
Legislative changes in the 99th Congress 724
Legislative changes in the 98th Congress 724

Section 9. SSI program description 730
Basic eligibility 730
Restrictions on SSI eligibility of residents of public institutions 731
Income exclusions 731
Resources 733
SSI benefits 735
Deeming of income and resources 738
State supplementation 739
Maximum SSI and food stamp benefits for individuals living independently 742
Comparison of SSI payment levels to poverty thresholds 747
Characteristics of the SSI population 749
SSI participation rates 755
Number of recipients: 1970–90 756
Impact of the *Sullivan* v. *Zebley* decision 759
Eligibility of SSI recipients for Medicaid 760
Eligibility of SSI recipients for food stamps 761
Special SSI benefits, Medicaid services, and related provisions for the working disabled 761
SSI outreach and special rehabilitation services 764
SSI and the homeless 764
SSI program costs 767

Section 10. Title XX social services block grant program 772
The evolution of the social services block grant program 772
Title XX allocation formula and historical funding levels 773
Title XX program goals 776
Data on services, recipients and expenditures under title XX 777
Transfer of funds among block grants 780
Title XX social services planning and program information 780
Reporting requirements of the Family Support Act of 1988 783

Section 11. Child welfare, foster care, and adoption assistance 784
Background 784
Federal child welfare programs today 789
Protections for children in foster care 821
Determining State compliance with Federal review requirements 828
Trends in foster care caseloads 836
Trends in child welfare costs 856
Title IV–E placement, administrative and training costs 858

Page

Foster care and adoption data and information collection system 862

Section 12. Tax expenditures and other tax provisions related to retirement, health, poverty, employment, and disability 866
Introduction 866
Concept of tax expenditures 866
Tax expenditure estimates 867
Net exclusion of pension contributions and earnings 870
Individual retirement plans 880
Exclusion of Social Security and railroad retirement benefits 883
Exclusion of employer contributions for medical insurance premiums and medical care 885
Cafeteria plans 888
Health care continuation rules 892
Exclusion of Medicare benefits 893
Deductibility of medical expenses 893
Earned income tax credit 897
Exclusion of public assistance and SSI benefits 905
Dependent care credit 906
Exclusion for employer-provided dependent care 912
Targeted jobs tax credit 913
Exclusion of workers' compensation and special benefits for disabled coal miners 916
Additional standard deduction for the elderly and blind 918
Tax credit for the elderly and certain disabled individuals 919
Tax expenditures related to housing 922
Low-income rental housing credit 928
Measurement of tax expenditures 932
Concepts used in distributional analysis 932

Section 13. The Pension Benefit Guaranty Corporation 934
Explanation of the Corporation and its functions 934
Financial condition of the PBGC 939
Financing 942
Legislative history 944
Budgetary treatment 946
Future financial status of the PBGC 947

Appendix G. Demographic, economic, and social characteristics of families with children 949
Introduction 949
Changing family composition 949
Living arrangements of children 952
Changing numbers of children 958
Statistical trends in teenage pregnancy 961
Public costs for teenage childbearing 974
Prenatal care 975
Infant mortality 983
Low birth weight 991
Drug-addicted mothers and their infants 993
Child health 994

Page

Educational achievement 1010
Dropout rates 1017
High school completion rates 1021
College completion rates 1023
Labor force participation of mothers 1024
Child care 1029
Child care facilities 1035
Employer child care practices 1035
The Federal role 1036
Income sources of families with children 1040
Trends in demographic characteristics and income composition of families with children 1047
Child poverty statistics 1050
Dynamics of childhood poverty 1056
Homelessness in America 1067
Combined impact of AFDC, food stamps, and Federal tax policy upon the income of female-headed families: 1960 to 1990 1072
Study methodology 1091

Appendix H. Demographic and economic characteristics of the elderly 1096
Population 1096
Trends in life expectancy 1098
Marital status and living arrangements 1098
Labor force participation 1100
Poverty status of the elderly 1101
Income sources of the elderly 1103
Housing arrangements of the elderly 1119
Present values of Social Security and Medicare taxes and benefits 1120

Appendix I. Poverty, income, and antipoverty effectiveness 1132
Poverty statistics 1132
International comparisons of the poverty of families 1148
Antipoverty effectiveness of various cash, near-cash and noncash income sources 1159
Explanations for increases in poverty between 1979 and 1989 1173
Trends in family income and income inequality 1183
Trends in income, benefits, and taxes, 1979–89 1220
Trends in family income and income inequality: 1950–80. 1261

Appendix J. Federal and State tax distribution for different family types 1263
Hypothetical tax calculations for selected families 1263
Tax treatment of the elderly 1264
Federal tax treatment of families in poverty 1272
State income and Sales Taxes 1276
The distribution of Federal taxes, 1977–92 1286
Description of tables 1293
Comparison of payroll and individual income taxes 1298

Appendix K. Statistics on the wealth status of households 1330

Appendix L. Federal spending on children and the elderly 1342

Page

Appendix M. Selected economic, population, and income data for the United States and by State 1353

Appendix N. Quality control systems 1363
- Measurement of error 1364
- Administration 1365
- Corrective action 1365
- Sanctions 1365
- Description of revised AFDC QC System 1366
- Quality control statistics 1370
- Historical perspective of quality control in the AFDC program 1372

Appendix O. Description of other major Federal assistance programs not within the jurisdiction of the Committee on Ways and Means 1383
- Food stamp program 1385
  - Administration, program variations, and funding 1385
  - Eligibility 1389
  - Benefits 1395
  - Interaction with cash assistance programs 1397
  - Food stamp participation rates 1400
  - Legislation 1401
- Medicaid 1404
  - Eligibility 1404
  - The medically needy (all optional) 1408
  - Medicaid and the poor 1409
  - Services 1410
  - Financing 1411
  - Reimbursement policy 1411
  - Administration 1412
  - Recent legislative changes 1412
  - Program data 1414
- Federal housing assistance 1438
  - Trends in Federal housing assistance 1438
  - Budget authority and outlays for housing assistance . 1444
- School lunch and breakfast programs 1448
- The special supplemental food program for women, infants and children (WIC) 1451
- Job Training Partnership Act 1453
- Head Start 1457
- Low Income Home Energy Assistance program 1459
  - Allotments to States 1459
  - Eligibility and types of assistance 1460
  - Planning and administration 1461
- Veterans' benefits and services 1466
  - Veterans compensation and veterans pensions 1466
  - Readjustment, education, and training benefits 1466
  - Medical programs 1467
  - Housing and loan programs 1469
  - Trends in use and costs 1469

Appendix P. Federal social welfare programs in outlying areas 1471

Page

PART 2. TRUST FUNDS WITHIN THE REVENUE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS WHICH PROVIDE BENEFITS TO INDIVIDUALS

Section 1. Black lung disability trust fund 1477

Section 2. Railroad retirement system 1483

Section 3. Railroad unemployment compensation system 1498

Section 4. Vaccine injury compensation trust fund 1504

PART 3. BUDGET TABLES, DESCRIPTION OF FISCAL YEAR 1990 ADMINISTRATION BUDGET PROPOSALS, AND DESCRIPTION OF THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985

Section 1. Budget tables 1507

Section 2. Description of proposals affecting programs within the jurisdiction of the Committee on Ways and Means 1558
- Medicare 1558
- Social Security and railroad retirement 1566
- Child support enforcement 1567
- Supplemental security income 1568
- Unemployment compensation 1568
- Child welfare services and foster care 1569
- AFDC and the title XX social services block grant 1569
- Trade adjustment assistance 1570
- Selected tax, user fee, and other proposals 1570

Section 3. Description of the Congressional Budget Process and Sequestration Under the Gramm-Rudman-Hollings Act 1575
- Introduction 1575
- Brief overview of the congressional budget process 1576
- The Gramm-Rudman-Hollings Act and the sequestration process 1581
  - Legislative history of the Gramm-Rudman-Hollings Act 1581
  - Summary of the sequestration process 1584
  - Sequestration reports and orders 1585
  - Deficit targets 1587
  - Discretionary spending limits 1589
  - Pay-as-you-go (PAYGO) procedures 1590
  - Sequestration estimates and calculations 1592
    - Baseline estimates 1592
    - Budgetary resources and PPAs 1593
    - Calculations 1594
    - Exemptions, special rules, and treatment of administrative expenses 1596
  - Suspension of the sequestration process 1600
  - Modification of sequestration orders 1601
- Enforcement procedures for Social Security 1602
- Sequestration actions for fiscal years 1986–91 1603

Page

The President's budgetary proposals for fiscal year 1992: Conformity to budget enforcement procedures 1607

Appendix Q. Excerpts from the Congressional Budget and Impoundment Control Act of 1974, and Subtitles C and E of title XIII of the Budget Enforcement Act of 1990 1611

Appendix R. Committee on Ways and Means March 1991 report to the Budget Committee 1639

PART 1

DESCRIPTION OF PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS PROVIDING BENEFITS OR SERVICES TO INDIVIDUALS

Section 1. The Old-Age and Survivors Insurance Program (OASI)

The old-age and survivors insurance (OASI) program provides monthly benefits to retired workers and their dependents and to survivors of insured workers. Old-age retirement benefits were provided for retired workers by the original Social Security Act of 1935, and benefits for dependents and survivors were provided by the 1939 amendments. The disability insurance (DI) program, enacted in 1956, and the hospital insurance (HI) program, enacted in 1965, are closely related to the old-age and survivors insurance program. (These related programs are discussed in later sections.)

GENERAL

A worker builds protection under these programs through employment that is covered by the Social Security system. Coverage is generally compulsory. However, employees of State and local governments who are not members of a public retirement system are covered on a voluntary group basis.[1] Currently, 94 percent of the Nation's paid work force is covered either voluntarily or mandatorily.

Contributions are made under the Federal Insurance Contributions Act (FICA, chapter 21 of the Internal Revenue Code). Contributions are based on wages and earnings up to the annual maximum taxable wage base ($53,400 in 1991 for OASDI and $125,000 for HI). The employee contribution is withheld from wage and salary payments to employees and is matched by employers. Self-employed persons (SECA, chapter 2 of the Internal Revenue Code) pay contributions on their net earnings annually up to the same maximum as employees, but at a rate that is equal to the combined employee-employer tax rate. However, the self-employed may deduct 7.65 percent from their net earnings before computing their Social Security tax and may also deduct half of their Social Security tax as a business expense.

Revenue from the OASI portion of the tax is credited automatically to the Old-Age and Survivors Insurance Trust Fund. In addition, the revenue derived from the taxation of a portion of Social Security retirement and survivors' benefits is credited to the OASI trust fund. The trust fund is the source of payment for: (1) monthly benefits when the worker retires or dies (including a financial interchange with the railroad retirement system), and (2) administrative expenses for the program.

---

[1] State and local coverage is voluntary for the OASI and DI programs. However, it became mandatory for HI purposes for persons hired by State or local governments on or after April 1, 1986.

BENEFITS

Summary

Monthly cash benefits under OASI are paid as a matter of earned right to workers who are insured for benefits and to their eligible dependents and survivors. Generally, benefit amounts paid both to the insured worker and to the insured worker's dependents or survivors are related to the past earnings of the insured worker. An individual may be entitled to benefits as a worker based on his own earnings history and also to benefits as a dependent of another worker. However, the amount of the benefit is adjusted so that, in effect, only the larger of the two benefits is paid.

In December 1990, there were 39.8 million beneficiaries in the OASI and DI programs who were in current-payment status. Monthly benefits paid out were $21.7 billion.

The following table summarizes various types of beneficiaries and average benefit amounts:

TABLE 1.—OASDI CASH BENEFITS IN CURRENT-PAYMENT STATUS, DECEMBER 1990

	Number (thousands)	Percent of beneficiary population	Average monthly benefit
Total monthly beneficiaries	39,832	100.0	$544
Retired workers	24,838	62.4	603
Wives and husbands of retired workers	3,101	7.8	311
Children of retired workers	422	1.1	259
Disabled workers	3,011	7.6	587
Wives and husbands of disabled workers	266	.7	150
Children of disabled workers	989	2.5	164
Widowed mothers and fathers	304	.8	409
Surviving children	1,776	4.5	406
Widows and widowers	5,010	12.6	556
Disabled widow(er)s	101	.3	389
Parents	6	.01	482
Special age-72	7	.02	167

Source: Office of Research and Statistics, Social Security Administration.

Description of major benefit types

Child's benefit. Under the OASI program, a monthly benefit is payable to an unmarried child or eligible grandchild of a retired worker or a deceased worker who was fully or currently insured at death if the child or grandchild is: (1) under age 18; (2) a full-time elementary or secondary student under age 19; (3) a dependent disabled person aged 18 or over whose disability began before age 22. A grandchild is eligible for benefits on a grandparent's earnings record (or that of the spouse of such worker) if he lived with the grandparent and received at least one-half his support from the grandparent in the year before the grandparent became entitled to benefits or died, and the child's parents became disabled or died before the grandparent became entitled to benefits or died.

Lump-sum death benefit. A lump-sum payment is payable upon the death of a fully or currently insured worker to the surviving spouse who was living with the deceased worker or was eligible to receive monthly cash survivor benefits upon the worker's death. If there is no eligible spouse, the lump-sum death payment is payable to any child of the deceased worker who is eligible to receive monthly cash benefits as a surviving child. If there is no surviving spouse and no children of the worker eligible for monthly benefits, then the lump-sum death payment is not paid. The payment amount is $255.

Minimum benefit. The minimum benefit is the smallest benefit (before actuarial reduction or earnings test reduction) payable to a worker or his survivors/dependents. In 1977, the minimum benefit was frozen at $122 per month for all workers who reached age 62 or became disabled after 1978 and all survivors of workers who died after 1978. Legislation in 1981 eliminated the minimum benefit for all persons becoming eligible for benefits in January 1982 or later (except for certain members of religious orders who have taken a vow of poverty; such persons are exempt from the new law for 10 years). These persons have their benefits computed under the regular benefit computation rules. Persons eligible for benefits prior to January 1, 1982 are able to continue receiving the minimum benefit, which is subject to annual cost-of-living adjustments.

Mother's or father's benefit. A monthly benefit is payable to a widow (widower) or surviving divorced mother (father) if: (1) the deceased worker on whose account the benefit is paid was fully or currently insured at time of death and (2) the widow (widower) or surviving divorced mother (father) has one or more entitled children of the worker in her care. These payments continue until the youngest nondisabled child being cared for reaches age 16.

Parent's benefit. This is a monthly benefit payable to a dependent parent, age 62 or over, of a deceased fully insured worker.

Retired-worker (old-age) benefit. This is a monthly benefit payable to a retired worker aged 62 or over who is fully insured.

"Special age-72" benefit. This is a monthly benefit payable to certain persons born before January 2, 1900, who do not have sufficient quarters of coverage to qualify for a retired-worker benefit. The benefit is payable only for months in which the individual is a resident of the 50 States or the District of Columbia and receives no public assistance cash payments or SSI payments. It is reduced by the amount of any government pension (except workers' compensation and veterans' service-connected compensation) that the individual is receiving or is eligible to receive. When husband and wife are both eligible for these benefits, a full benefit is paid to each spouse.

Special minimum benefit. This is a benefit that is not based on the worker's average monthly wage or average indexed monthly earnings, but instead on his/her length (years) of covered employment. It is designed to help those who worked in covered employment for many years but had low earnings. The amount of the special minimum is computed by multiplying the number of years of coverage in excess of 10 and up to 30 by $11.50 for monthly benefits payable in 1979, with automatic cost-of-living increases applicable to years 1979 and later. The number of years of coverage equals the number obtained by dividing total creditable wages in 1937–50 by $900 (not to exceed 14), plus the number of years after 1950 and before 1991 for which the worker is credited with at least 25 percent of the annual maximum taxable earnings. For this purpose for years after 1978, annual maximum taxable earnings are defined as the "old-law" taxable earnings base (i.e., the hypothetical earnings base that would be in effect if the ad hoc increases in the base enacted in 1977 were disregarded). In addition, for years after 1990, a year of coverage is earned if the worker is credited with at least 15 percent of the "old-law" taxable earnings base. The special minimum benefit is not subject to the delayed-retirement-credit provisions.

Spouse's benefit. This is a monthly benefit payable to a spouse or divorced spouse of a retired worker under one of the following conditions: (1) currently married spouse is aged 62 or older or is caring for one or more of the worker's entitled children who are disabled or have not reached age 16; or (2) divorced spouse is aged 62 or older, is not married, and the marriage to the worker had lasted 10 years before the divorce became final.

Widow's or widower's benefit. This is a monthly benefit payable to a widow(er) or surviving divorced spouse of a worker fully insured at the time of death if he or she is unmarried, or remarriage occurred after the widow(er)'s first eligibility for benefits; and (a) is aged 60 or older or (b) aged 50–59 and has been disabled throughout a waiting period of 5 consecutive calendar months that began no later than 7 years after the month the worker dies or after the end of her entitlement to benefits as a widowed mother.

BENEFIT ELIGIBILITY: INSURED STATUS

Benefits can only be paid to workers, their dependents or survivors if the worker is "insured" for these benefits. Insured status is measured in terms of "quarters of coverage."

Prior to 1978, one quarter of coverage was earned for each calendar quarter in which a worker was paid $50 or more in wages for covered employment (except for agricultural labor). Since the beginning of 1978 the crediting of quarters of coverage has been on an annual rather than a quarterly basis. In 1978, a worker earned one quarter of coverage, up to a total of four, for each $250 of annual earnings reported from covered employment or self-employment. The amount of annual earnings needed for a quarter of coverage is subject to annual automatic increases, effective in January of each year, in proportion to increases in average wages in the economy. In 1991, the amount is $540 for workers.

For the purpose of the OASI program, there are two types of insured status: "fully insured" and "currently insured." Workers are fully insured for benefits for themselves and for their families if they have one quarter of coverage (earned at any time after 1936) for every four quarters elapsing after 1950, or the year of reaching age 21, if later, up to the year in which they reach age 62, become disabled, or die. Fully insured status is required for eligibility for all types of benefits except certain survivor benefits. A person must have at least six quarters of coverage to be fully insured. A person with 40 quarters of coverage is fully insured for life.

Workers are currently insured if they have six quarters of coverage during the thirteen calendar quarters ending with the quarter in which they died. Currently insured status by itself provides that the worker's surviving family members are eligible for child's, mother's, father's and lump-sum death benefits.

TABLE 2.—AMOUNT OF COVERED EARNINGS NEEDED TO EARN ONE QUARTER OF COVERAGE SINCE 1978

1978	$250
1979	260
1980	290
1981	310
1982	340
1983	370
1984	390
1985	410
1986	440
1987	460
1988	470
1989	500
1990	520
1991	540
1992	[1] 570
1993	[1] 600
1994	[1] 640
1995	[1] 670

[1] Based on updated Alternative II-B assumptions in 1990 Trustees Report.

Source: Office of the Actuary, Social Security Administration.

Table 3 indicates the type of insured status that is required for the various monthly benefit categories.

TABLE 3.—INSURED STATUS REQUIREMENTS FOR VARIOUS MAJOR BENEFIT CATEGORIES

Type of benefit	Basic eligibility requirements
Retirement	Fully insured.
Dependents:	
Wives, husbands	Worker entitled.
Mothers, fathers, children, grandchildren	Worker entitled.
Survivors:	
Dependent parents—age 62	Worker fully insured.
Widows, widowers	Worker fully insured.
Mothers, fathers, children	Worker fully or currently insured.
Lump-sum death	Worker fully or currently insured.

BENEFIT COMPUTATION

The amount of a monthly benefit award is determined by first computing an insured worker's average monthly wage (AMW) or—in the case of most workers who attain age 62, become disabled, or die after 1978—average indexed monthly earnings (AIME). The AMW is used in computing benefits under the old (pre-1979) benefit formula, and the AIME is used in computing benefits under the new (post-1978) benefit formula enacted in 1977. The AMW or AIME is linked (by a table or by a formula, respectively, in the law) to the monthly retirement benefit payable at that worker's normal retirement age. This amount is called the primary insurance amount (PIA). Benefits for dependents and survivors are calculated as a percentage of the insured worker's PIA. The calculated amounts may be subject to minimum levels, and all benefits are subject to maximum limits. Benefits payable to workers, spouses, widows, and widowers who choose to retire before their normal retirement age are subject to an actuarial reduction. Benefits payable to workers who choose to retire after their normal retirement age are subject to increase through the delayed retirement credit, as are the benefits payable to their widows and widowers. The delayed retirement credit is 3 percent per year for workers age 65 before 1990. Starting in 1990, the delayed retirement credit increases by one-half of 1 percent every other year until it reaches 8 percent in 2008.

The normal retirement age

The normal retirement age is the earliest age at which unreduced retirement benefits can be received. The normal retirement age is presently age 65, but will be gradually increased to age 67 beginning in 2000.[2] For persons reaching age 62 in 2000, the normal retirement age will be increased by 2 months—to age 65 and 2 months. In each succeeding year, the normal retirement age will be increased by 2 additional months until it reaches age 66 for persons attaining age 62 in 2005. The normal retirement age will then remain at age 66 for persons attaining age 62 through 2016. Beginning with persons attaining age 62 in 2017, the normal retirement age will again increase by 2 months each year, until it reaches age 67 for persons attaining age 62 in 2022 and later. (See table 4 for the exact schedule of increases in the normal retirement age.)

Average wage index

The Social Security Administration average wage index (AWI) is the national average of total wages. It is adjusted to be consistent with the AWI series before 1978. (Prior to 1978, the AWI was four times the average taxable wages reported to SSA for the first calendar quarter.) Currently, the AWI is based on wages subject to income taxes, as reported on W-2 forms filed by employers. (Contributions to certain deferred compensation plans, while not subject to income tax, will be included in the AWI for 1991 and later as a result of Public Law 101-239 (OBRA 1989).) The AWI for a calendar year is equal to the AWI for the prior year multiplied by the percentage increase in the average of the total wages tabulated from individuals' wages subject to income tax for that year (reported on W-2 forms), as compared to the average for the prior year.

---

[2] Changes in the normal retirement age are a result of the Social Security Amendments of 1983 (P.L. 98-21).

The increase in national average wages, as measured by the SSA AWI, is used to index a worker's earnings under the "wage-indexed" (AIME) benefit computation method and to automatically adjust certain wage-indexed program amounts (e.g., the maximum taxable wage base, the retirement earnings test exempt amounts and the "bend points" in the formulas for determining primary insurance amounts and maximum family benefits).

Average indexed monthly earnings (AIME)

The AIME is a dollar amount that represents the average monthly earnings, adjusted for the change in the average of total wages[3] in the economy (the SSA AWI), that was received by the worker during a number of years of his covered employment. Indexing creates an earnings record that reflects the value of the individual's earnings relative to national average earnings in the indexing year. The indexing year is the second year before the year in which the worker attains age 62 or, if earlier, becomes disabled or dies. Earnings after the indexing year are counted at their nominal value.

There are four steps in the calculation of the AIME: (1) indexing the worker's earnings for each year after 1950 by dividing the worker's posted earnings for the year being indexed by the average wages of all workers in that same year and multiplying this result by the average earnings in the indexing year, (2) determining the number of computation years—the number of years after 1950 (or the year of attainment of age 21, if later) and up to the year the worker attains age 62, becomes disabled, or dies, minus dropout years, generally 5 (minimum number of computation years is 2); (3) selecting the actual computation years, based on highest earnings, from any years after 1950; and (4) dividing the sum of earnings in the computation years by the total number of months in the computation years.

---

[3] Total wages includes wages that are not taxable for Social Security purposes (e.g., noncovered earnings and earnings above the taxable earnings base).

TABLE 4.—INCREASES IN NORMAL RETIREMENT AGE FOR PERSONS REACHING AGE 62 IN EACH YEAR AFTER 1998

Year of birth	Year of attainment of age 62	Normal retirement age
1937 and before	1999 and before	65.
1938	2000	65, 2 mo.
1939	2001	65, 4 mo.
1940	2002	65, 6 mo.
1941	2003	65, 8 mo.
1942	2004	65, 10 mo.
1943–54	2005–16	66
1955	2017	66, 2 mo.
1956	2018	66, 4 mo.
1957	2019	66, 6 mo.
1958	2020	66, 8 mo.
1959	2021	66, 10 mo.
1960 and later	2022 and later	67.

The indexed earnings histories (rounded to whole dollars) are illustrated in table 5 for three different workers retiring in 1991 at age 62. The actual earnings for the three workers are shown in the first three columns. These are multiplied by the indexing factor (column 4) to arrive at indexed earnings (last 3 columns of table 5). The indexing factor for 1951 is average wages when an individual turned 60 ($20,099.55) divided by average wages for 1951 ($2,799.16). The lowest 5 years of indexed earnings may be dropped. For example, a lifelong full-time worker who had maximum-creditable earnings would be able to drop earnings in 1954, 1962, 1963, 1964, and 1965, and would have total indexed earnings of $1,172,836 (see table 5). Dividing this by the number of months in the computation period (35 years × 12 months = 420 months) results in an average indexed monthly earnings (AIME) of $2,792. The corresponding AIME's for the average and low (defined as 45 percent of average wages) earners are $1,677 and $754, respectively.

TABLE 5.—EARNINGS HISTORIES FOR HYPOTHETICAL WORKERS AGE 62 IN 1991

[Rounded to nearest dollar]

Year	Nominal earnings			Indexing factor	Indexed earnings		
	Low [1]	Average [2]	Maximum [3]		Low [1]	Average [2]	Maximum [3]
1951	1,260	2,799	3,600	7.1806	[4] 9,045	[4] 20,100	25,850
1952	1,338	2,973	3,600	6.7600	[4] 9,045	[4] 20,100	24,336
1953	1,413	3,139	3,600	6.4023	[4] 9,045	[4] 20,100	23,048
1954	1,420	3,156	3,600	6.3694	[4] 9,045	[4] 20,100	[4] 22,930
1955	1,486	3,301	4,200	6.0881	[4] 9,045	[4] 20,100	25,570
1956	1,590	3,532	4,200	5.6901	9,045	20,100	23,899
1957	1,639	3,642	4,200	5.5192	9,045	20,100	23,181
1958	1,653	3,674	4,200	5.4711	9,045	20,100	22,978
1959	1,735	3,856	4,800	5.2128	9,045	20,100	25,021
1960	1,803	4,007	4,800	5.0160	9,045	20,100	24,077
1961	1,839	4,087	4,800	4.9182	9,045	20,100	23,607
1962	1,931	4,291	4,800	4.6837	9,045	20,100	[4] 22,482
1963	1,978	4,397	4,800	4.5716	9,045	20,100	[4] 21,944
1964	2,059	4,576	4,800	4.3921	9,045	20,100	[4] 21,082
1965	2,096	4,659	4,800	4.3144	9,045	20,100	[4] 20,709
1966	2,222	4,938	6,600	4.0701	9,045	20,100	26,863
1967	2,346	5,213	6,600	3.8553	9,045	20,100	25,445
1968	2,507	5,572	7,800	3.6074	9,045	20,100	28,138
1969	2,652	5,894	7,800	3.4103	9,045	20,100	26,600
1970	2,784	6,186	7,800	3.2491	9,045	20,100	25,343
1971	2,924	6,497	7,800	3.0936	9,045	20,100	24,130
1972	3,210	7,134	9,000	2.8175	9,045	20,100	25,358
1973	3,411	7,580	10,800	2.6516	9,045	20,100	28,637
1974	3,614	8,031	13,200	2.5028	9,045	20,100	33,037
1975	3,884	8,631	14,100	2.3288	9,045	20,100	32,836
1976	4,152	9,226	15,300	2.1785	9,045	20,100	33,330
1977	4,401	9,779	16,500	2.0553	9,045	20,100	33,912
1978	4,750	10,556	17,700	1.9041	9,045	20,100	33,702
1979	5,166	11,479	22,900	1.7509	9,045	20,100	40,096
1980	5,631	12,513	25,900	1.6062	9,045	20,100	41,601
1981	6,198	13,773	29,700	1.4593	9,045	20,100	43,342
1982	6,539	14,531	32,400	1.3832	9,045	20,100	44,815
1983	6,858	15,239	35,700	1.3189	9,045	20,100	47,086
1984	7,261	16,135	37,800	1.2457	9,045	20,100	47,088
1985	7,570	16,823	39,600	1.1948	9,045	20,100	47,314
1986	7,795	17,322	42,000	1.1604	9,045	20,100	48,735
1987	8,292	18,427	43,800	1.0908	9,045	20,100	47,777
1988	8,700	19,334	45,000	1.0396	9,045	20,100	46,782
1989	9,045	20,100	48,000	1.0000	9,045	20,100	48,000
1990	[5] 9,531	[5] 21,179	51,300	1.0000	[5] 9,531	[5] 21,179	51,300

---

[1] Worker with earnings equal to 45 percent of the SSA average wage index.

[2] Worker with earnings equal to the SSA average wage index.

[3] Worker with earnings equal to the Social Security maximum taxable earnings.

[4] Dropout years.

[5] Estimate based on updated Alternative II–B assumptions in 1990 Trustees Report.

Average monthly wage (AMW)

The AMW, which is used in computing benefits under the old pre-1979 benefit formula, is computed by: (1) determining the number of computation years—the number of years after 1950 (or the year of attainment of age 21, if later) and up to the year the worker attains age 62 (age 65 for men born before January 2, 1911, and the later of age 62 or the year 1975 for men born after January 1, 1911), onset of disability or death, minus dropout years, generally 5 (minimum number of computation years is 2); (2) selecting the actual computation years, based on highest nonindexed earnings, from any years after 1950; and (3) dividing the sum of nonindexed earnings in the computation years by the total number of months in the computation years.

Primary insurance amount (PIA)

The monthly benefit amount payable to a retired worker who begins to receive benefits at his normal retirement age is his PIA rounded to the next lower dollar, if not already a multiple of $1. The PIA is used as a base for computing all benefits which are payable on the basis of that worker's earnings record.

The method of determining the PIA generally depends on whether an AIME or an AMW was computed for the worker. (This, of course, depends on the worker's date of birth.) If an AMW has been computed for the worker, the PIA is determined through reference to benefit tables which are updated and published annually. Under a transitional guarantee provision of the 1977 amendments (which is applicable only to workers who attain age 62 in 1979–83), the PIA is determined on the basis of the frozen 1978 benefit table if it is higher than under the AIME method.

Other methods for determining a PIA also exist and PIA's based on different methods must be compared to select the highest one. This highest PIA actually determines the worker's benefits. The most common of these other PIA's is the special minimum PIA. This PIA is designed to assist workers with long-term low earnings.

In cases where an AIME has been computed, the PIA is determined by applying the "primary benefit formula" to the AIME. For a worker reaching age 62 in 1991, the PIA equals 90 percent of the first $370 of AIME, 32 percent of the next $1,860 of AIME, and 15 percent of the AIME above $2,230. Applying this formula to the AIME's of the three example workers results in PIA's of $455.80 for the low-wage worker, $751.20 for the average-wage worker, and $1,012.50 for the maximum-wage worker. For the low-wage worker (a worker with wages equal to 45 percent of average wages), the 1991 special minimum PIA of $461.20 exceeds the AIME-based PIA of $455.80, and is therefore used to determine his or her benefits.

The numbers $370 and $2,230 are often referred to as "bend points" of the PIA formula. These are adjusted each year by the change in average wages.

Beginning with the year of initial eligibility (age 62 for retired worker benefits), the PIA is increased each year for the increase in the Consumer Price Index (CPI). Thus, the PIA's of $461.20, $751.20, and $1,012.50 would be in effect for January through November 1991, and will be increased by the cost-of-living adjustment that will increase benefits beginning December 1991 under current law.

BENEFIT AMOUNTS

The monthly benefit amount payable to a retired worker who begins to receive benefits at this normal retirement age is the PIA rounded to the next lower dollar, if not already a multiple of $1.

Workers attaining age 62 before 2000 (the year in which the retirement age begins to increase) who retire before age 65 will receive a benefit with an actuarial reduction. Retirement after normal retirement age results in an actuarial increase in the benefit payable.

TABLE 6.—SCHEDULE OF BENEFITS, AS A PERCENTAGE OF PIA, PAYABLE AT SELECTED AGES, FOR PERSONS REACHING AGE 62 IN EACH YEAR 1986 AND LATER

Year of attainment of age 62	Benefit, as a percentage of PIA, if retiring at age—		
	62	65	67
1986	80	100	106
1987	80	100	107
1988	80	100	107
1989	80	100	108
1990	80	100	108
1991	80	100	109
1992	80	100	109
1993	80	100	110
1994	80	100	110
1995	80	100	111
1996	80	100	111
1997	80	100	112
1998	80	100	112
1999	80	100	113
2000	79⅙	98 8/9	111 11/12
2001	78⅓	97 7/9	111⅔
2002	77½	96⅔	110½
2003	76⅔	95 5/9	110
2004	75⅚	94 4/9	108¾
2005–16	75	93⅓	108
2017	74⅙	92 2/9	106⅔
2018	73⅓	91 1/9	105⅓
2019	72½	90	104
2020	71⅔	88 8/9	102⅔
2021	70⅚	87 7/9	101½
2022 and later	70	86⅔	100

After the year 2000, the minimum age of eligibility for reduced benefits will remain unchanged at age 62 (age 60 for widows and widowers). However, there will be increases in the amount of reduction for early retirement. The amount of reduction will be 5/9 of

1 percent for each of the first 36 months of early retirement (as under present law), and 5/12 of 1 percent for each month in excess of 36. Thus, for persons attaining age 62 during 2005–16, for whom the normal retirement age will be 66, the reduced benefit payable at age 62 will be 75 percent of the PIA. For persons attaining age 62 in 2022 and later, for whom the normal retirement age will be 67, the reduced benefit payable at age 62 will be 70 percent of the PIA. (See table 6.) There will be no increase in the maximum reduction for widow(er)s.

Auxiliary benefit amounts are also based on the worker's PIA. Table 7 lists major types of benefits with the percent of the insured worker's PIA which is paid.

TABLE 7.—PERCENTAGE OF PRIMARY INSURANCE AMOUNT (PIA) PAID FOR DEPENDENT'S AND SURVIVOR'S BENEFITS

Type of monthly benefit	Percent of PIA
Dependents: [1]	
Wives, husbands—age 65	[3] 50.0
Mothers, fathers, children, grandchildren	50.0
Survivors: [1]	
Widows, widowers—age 65 [2]	[3] 100.0
Dependent parent—age 62	82.5
Widows, widowers, disabled—age 50	71.5
Mothers, fathers, children	75.0

[1] Subject to maximum family benefit limitation.

[2] Subject to general limitation that survivor cannot get a higher benefit than deceased worker would be getting if alive.

[3] These percentages decrease as the normal retirement age increases beginning in the year 2000.

REPLACEMENT RATES

Frequently Social Security benefits are discussed in terms of how much of a person's preretirement earnings the benefits represent. Benefits expressed as a percent of earnings are called replacement rates. The following table shows replacement rates based on the PIAs of hypothetical workers who retired at age 65 after full-time careers with steady earnings equal to: (1) 45 percent of average earnings in the economy (as recorded through the Social Security average wage index), (2) 100 percent of average earnings in the economy, and (3) the maximum earnings taxable each year for FICA and SECA tax purposes.

TABLE 8.—SOCIAL SECURITY REPLACEMENT RATES, 1940–2040

[In percent]

Year of attaining normal retirement age	Replacement rates[1]		
	Low earner[2]	Average earner	Maximum earner[3]
1940	39.4	26.2	16.5
1950	33.2	19.7	21.2
1960	49.1	33.3	29.8
1965	45.6	31.4	32.9
1970	48.5	34.3	29.2
1975	59.9	42.3	30.1
1976	60.1	43.7	32.1
1977	61.0	44.8	33.5
1978	63.4	46.7	34.7
1979	64.4	48.1	36.1
1980	68.1	51.1	32.5
1981	72.5	54.4	33.4
1982	65.8	48.7	28.6
1983	63.5	45.8	26.4
1984	62.7	42.9	23.7
1985	61.2	40.9	22.8
1986	60.4	41.2	23.1
1987	59.6	41.3	22.6
1988	58.4	40.9	23.1
1989	57.9	41.7	24.1
1990	58.3	43.2	24.5
2000	56.0	41.6	25.1
2010	55.5	41.3	26.5
2020	55.5	41.3	27.2
2030	55.1	41.1	27.1
2040	56.1	41.1	27.1

[1] Total monthly benefits payable for year of entitlement at normal retirement age expressed as percent of earnings in year prior to entitlement for workers with steady career earnings. Normal retirement age will rise starting with workers who attain age 62 in 2000 and will ultimately reach age 67 for workers attaining age 62 in 2022 and later. Projections for 1990 and later are based on the intermediate II–B assumptions of the 1990 OASDI Trustees' Report.

[2] Earnings equal to 45 percent of the average wage as determined by Social Security.

[3] Earnings equal to the maximum wage taxable for Social Security purposes.

Source: Office of the Actuary, Social Security Administration.

BENEFIT REDUCTION AND INCREASE

Social Security benefits may be reduced, withheld or increased for several reasons, chiefly on account of early retirement or delayed retirement, and on account of earnings in excess of the exempt amount provided in the law ($7,080 in 1991 for beneficiaries under age 65, and $9,720 for beneficiaries age 65–69). In addition, there is an overall limit on the total amount of benefits which can be paid at one time on the basis of any one earnings record.

Actuarial reduction. This is the reduction in the monthly benefit amount payable: (a) on entitlement at ages 62–64 if the beneficiary is a retired worker, a spouse of a retired or disabled worker (with entitlement not dependent on having a child beneficiary in his/her care), or a divorced spouse; (b) on entitlement at age 60–64 if the beneficiary is a widow, widower, or a surviving divorced spouse; or (c) on entitlement, in case of disability, at ages 50–59 if the beneficiary is a widow, widower, or surviving divorced spouse.

At the time of award, the following reductions in benefit amount are made for:

A retired-worker beneficiary—5/9 of 1 percent for each month of entitlement before age 65 (maximum reduction of 20 percent);

A wife or husband beneficiary—25/36 of 1 percent for each month of entitlement before age 65 (maximum reduction of 25 percent);

A widow(er) including surviving divorced spouse—19/40 of 1 percent for each month of entitlement between age 60 (maximum reduction of 28.5 percent) and age 65. Disabled widow(er)s ages 50 to 59 receive 71.5 percent of the PIA.

The benefit continues to be paid at a reduced rate even after age 65, except that the reduced rate is refigured at age 65 for all beneficiaries and also at age 62 for a widow, widower, and a surviving divorced spouse to omit months for which the reduced benefits was not paid and to take into account any additional earnings. Data on benefits paid to all retired workers in 1990 indicates that 68 percent of all such benefits were actuarially reduced (65 percent for men, 73 percent for women). Table 19 presents information on the number of workers retiring in a given year who file for actuarially reduced benefits.

Delayed retirement credit (DRC). A credit for delayed retirement is due a worker for each month the worker: (1) was fully insured, (2) had attained age 65 but was not yet age 70, and (3) did not receive benefits because the worker had not filed an application or was working. Each monthly credit serves as a basis for increasing the monthly benefit (unless the benefit is based on a special minimum PIA) by 1/12 of 1 percent for workers who attained age 62 before 1979 and by ¼ of 1 percent for workers attaining age 62 from 1978 through 1986. The increase is applicable to the worker's monthly benefits amount but not to the PIA. Hence, auxiliary benefits are generally not affected. The exception is that a surviving spouse (including divorced) receiving widow(er)'s benefits is entitled, for months after May 1978, to the same increase that had been applied to the benefit of the deceased worker or for which the worker was eligible for at the time of death.

As a result of the Social Security Amendments of 1983, beginning with workers who attain age 65 in 1990 (i.e., age 62 in 1987) the increment for delaying retirement past the normal retirement age will increase by ½ of 1 percent every second year until reaching 8 percent per year of delayed retirement for workers attaining age 65 after 2007.

Maximum family benefit. The maximum monthly amount that can be paid on a worker's earnings record varies with the PIA. For benefits payable on the earnings records of retired and deceased workers, the maximum varies between 150 and 188 percent of the PIA. No more than the established maximum can be paid to a family regardless of the number of beneficiaries entitled on that earnings record. The family maximum is computed by adding fixed percentages of dollar amounts which are part of the PIA. For the family of a worker who becomes age 62 or dies in 1991, the total amount of benefits payable to them will be:

150 percent of the first $473 of PIA, plus;
272 percent of PIA from $473 through $682, plus;
134 percent of PIA from $682 through $890 plus;
175 percent of PIA over $890.

The dollar amounts in this benefit formula (i.e. the "bend points") are adjusted annually by the same index used to update the bend points in the primary benefit formula.

Whenever the total of the individual monthly benefits payable to all the beneficiaries entitled on one earnings record exceeds the maximum, each dependent's or survivor's benefit is proportionately reduced to bring the total within the maximum.

In computing the total of the individual monthly benefits for entitlements based on a single earnings record, a benefit payable to a divorced spouse or to a surviving divorced spouse is not included.

Retirement test. The retirement test is a provision in the law that reduces benefits for nondisabled recipients who earn income from work above a certain amount.

The test has been modified many times over the years. In 1991, the law provides that beneficiaries under age 65 may earn up to $7,080 a year in wages or self-employment income without their benefits being affected. Beneficiaries age 65–69 can earn up to $9,720 a year. For beneficiaries under age 65 who have earnings in excess of these amounts, $1 of benefits is lost for each $2 of earnings. For beneficiaries age 65–69, the reduction rate is $1 of benefits lost for every $3 of earnings in excess of the exempt amount. The exempt amounts are adjusted each year to rise in proportion to average wages in the economy. The test does not apply to beneficiaries age 70 and over (they receive full benefits regardless of the level of their earnings). In the first year of entitlement—and last year for dependent beneficiaries—the so-called "grace year"—a beneficiary may use a monthly test of earnings rather than the annual test, if it is more advantageous. Under the monthly test, a beneficiary may receive benefits for any month in which his or her earnings do not exceed one-twelfth of the annual exempt amount regardless of annual earnings. However, under this monthly test, if earnings in a month exceed one-twelfth of the annual exempt amount, no benefit is paid for that month. The monthly test is used only when it is more beneficial to the individual. For the self-employed, excess earnings cannot be charged to any month in which the individual does not perform "substantial services" in his or her trade or business.

Retired workers whose benefits are not paid due to the retirement test for one or more months are compensated through future increases in their benefit amount. For workers under age 65, their actuarial reduction factor is reduced. Beneficiaries age 65–69 get a DRC for each month benefits were not paid.

Examples:

1. John—Age 63 with $4,000 in annual benefits before the retirement test is applied:

Earnings in 1991	$8,080
Exempt amount for under age 65	7,080
Excess over exempt amount	1,000
Benefit reduction = 50 percent of excess	500
Benefits John will receive in 1991	3,500

2. Ida—Age 67 with $4,000 in annual benefits before the retirement test is applied:

Earnings in 1991	10,320
Exempt amount for 65 and older	9,720
Excess over exempt amount	600
Benefit reduction = 33 percent of excess	200
Benefits Ida will receive in 1991	3,800

The test does not apply to pensions, rents, dividends, interest, and other types of "unearned" income. These forms of income were exempted in order to encourage savings for retirement as supplements to Social Security.

History of the retirement test.—The retirement test was part of the original plan that led to Social Security. The 1935 report of the Committee on Economic Security appointed by President Franklin D. Roosevelt recommended that no benefits be paid before a person had "retired from gainful employment." Initially, the Social Security Act provided that benefits would not be paid for any month in which the individual had received "wages with respect to regular employment." Before any benefits were payable under the program, Congress modified this provision in the Social Security Amendments of 1939. No benefits would be paid for any month in which wages from covered employment were $15 or more. This arrangement prevailed until 1950.

The 1950 amendments extended Social Security coverage to the bulk of nonfarm self-employed workers. It was claimed that many self-employed people never retired and therefore would never receive benefits. As a result, the 1950 act exempted persons age 75 and over from the test. In addition, in the first of many actions to increase the amount of earnings permitted, allowable monthly income from wages was increased from $14.99 to $50.

Over the years, the earnings limits, the age limits, and the formulae for reducing benefits have been changed many times. Starting with the 1954 amendments, benefits were no longer totally withheld if the retiree had earnings above the exempt amount. Instead, a reduced benefit was payable. The 1972 amendments reduced benefits by $1 for every $2 of earnings above the exempt amount. The 1972 amendments also provided that, beginning in 1975, the exempt amounts would be "indexed" to rise at the same rate as wage growth. To compensate workers who did not receive benefits between ages 65 and 72, including those who did not because of the retirement test, the amendments established the delayed retirement credit.

In the consideration of major Social Security legislation in 1977, there was considerable pressure to eliminate the retirement test for persons over age 65. As a compromise, the limit on earnings was raised for persons age 65 and older, and since then two different exempt amounts have applied for those under and over age 65. The 1977 amendments also lowered from 72 to 70 the age at which the test would no longer apply, to be effective in 1982 (subsequent legislation postponed the effective date to 1983). In response to criticism that it discriminated in favor of workers who had substantial but irregular employment (e.g., teachers), Congress also eliminated the monthly test except for the first year of retirement. In 1980, Congress extended the monthly test to the year a dependent beneficiary became ineligible for benefits.

TABLE 9.—RETIREMENT TEST EXEMPT AMOUNTS

Year	Under age 65	Age 65 and over [1]
1975	$2,520	$2,520
1976	2,760	2,760
1977	3,000	3,000
1978	3,240	4,000
1979	3,480	4,500
1980	3,720	5,000
1981	4,080	5,500
1982	4,440	6,000
1983	4,920	6,600
1984	5,160	6,960
1985	5,400	7,320
1986	5,760	7,800
1987	6,000	8,160
1988	6,120	8,400
1989	6,480	8,880
1990	6,840	9,360
1991	7,080	9,720
1992	[2] 7,440	[2] 10,200
1993	[2] 7,800	[2] 10,800
1994	[2] 8,280	[2] 11,400
1995	[2] 8,760	[2] 12,000

[1] In 1955–82, retirement earnings test did not apply at ages 72 and over; beginning in 1983, it does not apply at ages 70 and over.

[2] Based on updated Alternative II–B assumptions in 1990 Trustees Report.

Source: Office of the Actuary, Social Security Administration.

As part of major legislation restoring financial integrity to Social Security in 1983, Congress made two liberalizations affecting persons who continue to work after attaining retirement age. The first provided that beginning in 1990 beneficiaries who have attained the normal retirement age will lose only $1 in benefits for each $3 in earnings above the exempt amount. The second increased the delayed retirement credit (DRC). Prior to the increase, the DRC was equal to ¼ of 1 percent for each month (3 percent a year) beyond the normal retirement age that a person did not receive benefits. Under the 1983 provision, the DRC will increase gradually to ⅔ percent a month over the period 1990 to 2009 (8 percent a year).

As a result of a legislative change in the Deficit Reduction Act of 1984, the Social Security Administration has begun to request earlier reports of earnings from beneficiaries who are most likely to have earnings in excess of the exempt amount. These beneficiaries may thus have their benefits ceased in the actual year of excess earnings, rather than receiving overpayments which must then be recouped later.

Impact of the retirement test.—In 1986, more than 8 million people age 65 to 69 received or were eligible to receive Social Security benefits. Almost one-fifth of this group—nearly 1.6 million people—had some earnings in 1986, but only 600,000 of them had their Social Security benefits reduced because of the retirement test. Thus, only 10 percent of persons age 65 to 69 who were eligible for benefits were affected by the test. The other 90 percent either did not work or had earnings below the exempt amount.

Those affected by the retirement test are more likely than those not affected: to be men; to live with their spouses; to have family incomes above $32,000; and to have family incomes above four times the poverty threshold—that is, more than approximately $21,000 for a single person and approximately $26,500 for a couple.

Beneficiaries affected by the retirement test tend to have higher family incomes than those not affected by the test. While only one-eighth of all beneficiaries had family incomes in 1986 above $42,000, more than 40 percent of those affected by the retirement test had incomes above that level. Table 10 shows the distribution by family income of those affected by the retirement test.

TABLE 10.—DISTRIBUTION IN 1986 OF PEOPLE AGED 65–69 ELIGIBLE TO RECEIVE SOCIAL SECURITY BENEFITS, BY FAMILY INCOME AND EARNINGS

[In percent]

Annual family income	Entire group	With no earnings	Earnings under limit	Earnings over limit
Men:				
Under $10,000	18	21	13	1
$10,000 to $14,999	16	18	19	2
$15,000 to $24,999	28	30	33	14
$25,000 to $31,999	11	11	11	12
$32,000 to $41,999	12	11	10	20
$42,000 to $49,999	4	4	3	9
$50,000 to $74,999	7	5	7	21
$75,000 and over	4	1	3	23
All incomes	100	100	100	100
Women:				
Under $10,000	26	28	21	(1)
$10,000 to $14,999	17	16	21	10
$15,000 to $24,999	27	26	32	28
$25,000 to $31,999	11	11	10	14
$32,000 to $41,999	9	8	8	23
$42,000 to $49,999	3	3	3	4
$50,000 to $74,999	5	5	4	14
$75,000 and over	2	2	1	8
All incomes	100	100	100	100
Men and women:				
Under $10,000	22	25	18	(1)
$10,000 to $14,999	17	17	20	5
$15,000 to $24,999	28	28	32	19
$25,000 to $31,999	11	11	10	12
$32,000 to $41,999	10	9	9	21
$42,000 to $49,999	4	3	3	7
$50,000 to $74,999	6	5	6	18
$75,000 and over	3	2	2	17
All incomes	100	100	100	100

[1] Less than 0.5 percent.

Notes.—Details may not add to totals because of rounding. Income is distinct from earnings: earnings are wages, salaries, and income from self-employment, and are only part of total income.

Source: Congressional Budget Office tabulations of data from the March 1987 Current Population Survey.

Withholding. This is the suspension of benefit payments until the conditions causing deductions are known to have ended. Reasons for withholding benefits include: (1) earnings by a beneficiary (or any dependent drawing benefits on his earnings record) under age 70 from either covered or noncovered employment which exceeds the annual allowable amount (the retirement test); (2) failure of a wife under age 62 or mother or father beneficiary to have an entitled child in her care; (3) for special age-72 beneficiaries, receipt of public assistance or supplemental security income (SSI) payments or government pensions; (4) the payee is not determined; and (5) administrative reasons.

Some of the administrative reasons for withholding benefits are: (a) refusal of beneficiary to accept checks for personal reasons; (b) beneficiary's residence in certain foreign countries; and (c) under certain conditions, an alien beneficiary's residence outside the United States for more than 6 full consecutive calendar months.

Suspension of monthly benefit payments does not affect eligibility for hospital insurance benefits.

BENEFITS FOR RECIPIENTS OF PENSIONS FROM NONCOVERED EMPLOYMENT

The public pension offset. Social Security benefits payable to spouses of retired, disabled, or deceased workers are generally reduced to take account of any public pension the spouse receives as a result of work in a government job not covered by Social Security. The amount of the reduction is equal to two-thirds of the government pension. The offset does not apply to workers whose government job is covered by Social Security on the last day of the person's employment.

Generally, Federal workers hired before 1984 are part of the Civil Service Retirement System (CSRS) and are not covered by Social Security. Federal workers hired after 1983 are covered by the Federal Employee's Retirement System Act of 1986 (FERS), which includes coverage by Social Security. The FERS law provided employees covered by the CSRS the opportunity from July 1, 1987, to December 31, 1987, to make a one-time election to join FERS and thereby obtain Social Security coverage. Thus, a CSRS employee who switched to FERS during this period immediately became exempt from the government pension offset.

The "windfall" benefit. Under the so-called "windfall" benefit provision of the Social Security Amendments of 1983, Social Security benefits are generally reduced for workers who also have pensions from work that was not covered by Social Security (e.g., work under the Federal Civil Service Retirement System). Under the regular, weighted benefit formula, benefits are determined by applying a percentage to average indexed monthly earnings. In 1991, benefits equal 90 percent of the first $370 of average indexed monthly earnings, 32 percent of earnings from $370 to $2,230, and 15 percent of earnings above $2,230. The formula applicable to those with pensions from noncovered employment substitutes 40 percent for the 90 percent factor in the first bracket. (The second and third factors remain the same.) The resulting reduction in the worker's Social Security benefit is limited to one-half the amount of the noncovered pension. The new law was phased in over a 5-year period beginning with those first eligible for Social Security benefits and noncovered pensions in 1986.

Workers who have 30 years or more of substantial Social Security coverage are fully exempt from this treatment. For workers who have 21-29 years of coverage, the percentage in the first bracket in the formula increases by 5 percentage points for each year over 20, as illustrated below:

Years of Social Security Coverage:	First factor in formula (percent):
20 or fewer	40
21	45
22	50
23	55
24	60
25	65
26	70
27	75
28	80
29	85
30 or more	90

AUTOMATIC BENEFIT ADJUSTMENTS

Benefit increases for Social Security and SSI recipients are based on increases in the cost of living as measured by the Bureau of Labor Statistics' Consumer Price Index (CPI). As a result of a provision contained in the Omnibus Budget Reconciliation Act of 1986, it is no longer necessary for the rise in the CPI to exceed 3 percent in order to trigger the annual cost-of-living adjustment (COLA). A COLA will now be provided in any year in which there is a measurable (0.1 percent) increase in consumer prices. If there was a year of price deflation and no COLA was provided, then a 2-year change in the CPI of at least 0.1 percent is needed before a COLA is provided.

Prior to 1984, the change in the CPI was measured from the first calendar quarter of the base year to the first calendar quarter of the current year. However, the benefit increases in 1984 and later years are based on the CPI increase from the third quarter of the base year through the third quarter of the year in which the benefit increase becomes effective. In addition, benefit increases beginning with the January 1986 check are based upon a price index in which the housing component is measured on a rental equivalence basis.

If the assets of the combined OASI and DI trust funds are below a certain reserve ratio (15 percent for 1984 through 1988, and 20 percent thereafter) and wages increase at a rate lower than inflation, the automatic benefit increase will be based on wage growth rather than inflation.

The Secretary of Health and Human Services (HHS) is required by law to publish the amount of the increase in the Federal Register within 45 days after the close of the measuring period. The benefit increase is effective in December and first appears in benefit checks received in January, i.e., 3 months after the close of the measuring period. (Prior to 1983 the benefit adjustment was effective in June and payable in July.)

For example, since a benefit increase was effective in 1989, that year became the base for the 1990 benefit increase. The CPI for the third quarter of 1989 was 123.3. This was the arithmetical average of the CPI for July, August and September, 1989.

Month in 1989:	CPI
July	123.2
August	123.2
September	123.6
Total	370.0

The average CPI for the 3rd quarter of 1989 is thus:

370.0/3=123.3 (rounded to the nearest 0.1)

The CPI for the third quarter of 1990 was 129.9. This was the arithmetical average of the CPI for July, August and September, 1990.

Month in 1989:	CPI
July	128.7
August	129.9
September	131.1
Total	389.7

The average CPI-W for the third quarter of 1990 is thus:

389.7/3=129.9 (rounded to the nearest 0.1)

The percentage increase in the CPI from the third quarter of 1988 to the third quarter of 1990 is:

(129.9−123.3)/123.3=5.4 percent

Thus, the benefit increase for December 1990 was 5.4 percent (and was reflected in the January 1991 checks).

The benefit increase is always rounded to the nearest 0.1 percent. It applies to all types of beneficiaries.

TABLE 11.—HISTORICAL COMPARISON OF AVERAGE WAGE INCREASES TO BENEFIT INCREASES AND CHANGES IN CPI, 1965–90

[In percent]

	Increases in wages [1]		Increase in CPI [2]		Increase in benefits [3]	
	Over prior year	Cumulative from each year to 1990	Over prior year	Cumulative from each year to 1990	Over prior year	Cumulative from each year to 1990
1965	1.8	350.5	1.7	306.5	7.0	395.3
1966	6.0	324.9	2.9	295.0	0	395.3
1967	5.6	302.4	2.9	283.9	0	395.3
1968	6.9	276.5	4.2	268.4	13.0	338.3
1969	5.8	255.8	5.4	249.6	0	338.3
1970	5.0	238.9	5.9	230.1	15.0	281.2
1971	5.0	222.7	4.3	216.5	10.0	246.5
1972	9.8	193.9	3.3	206.4	20.0	188.8
1973	6.3	176.5	6.2	188.5	0	188.8
1974	5.9	161.1	11.0	159.9	11.0	160.1
1975	7.5	142.9	9.1	138.2	8.0	140.9
1976	6.9	127.2	5.7	125.4	6.4	126.4
1977	6.0	114.4	6.5	111.6	5.9	113.8
1978	7.9	98.7	7.6	96.7	6.5	100.7
1979	8.7	82.8	11.4	76.5	9.9	82.6
1980	9.0	67.7	13.5	55.5	14.3	59.8
1981	10.1	52.3	10.3	41.0	11.2	43.7
1982	5.5	44.3	6.0	33.0	7.4	33.8
1983	4.9	37.6	3.0	29.2	[4] 3.5	29.3
1984	5.9	29.9	3.4	24.9	3.5	24.9
1985	4.3	24.6	3.5	20.7	3.1	21.1
1986	3.0	20.9	1.6	8.8	1.3	19.6
1987	6.4	13.7	3.6	14.7	4.2	14.8
1988	4.9	8.4	4.0	10.2	4.0	10.4
1989	4.0	4.2	4.8	5.2	4.7	5.4
1990	[5] 4.2	....	5.2	....	[6] 5.4	....

---

[1] Average annual earnings series used to index earnings records.

[2] Increase in annual average CPI-W.

[3] Legislated benefit increases through 1975 and increases based on CPI thereafter. After 1975, the CPI and the benefit increases are different because they reflect the change in prices measured over different periods of time.

[4] As a result of the Social Security Amendments of 1983, COLA's are provided on a calendar year basis, with the benefit increase payable in January rather than July. The July 1983 COLA was delayed to January 1984. This delay and a change in the computation period led to 6 months of 1983 (first quarter–third quarter) not being accounted for in any COLA increase—a period during which the CPI increased 2.4 percent.

[5] Preliminary.

[6] Effective December 1990, payable January 3, 1991.

Source: Office of Research and Statistics, Social Security Administration.

TAXATION OF SOCIAL SECURITY (OASDI) BENEFITS FOR HIGHER INCOME PERSONS

Beginning in 1984, up to one-half of OASDI benefits (and railroad retirement tier 1 benefits) are included in taxable income for taxpayers with incomes above certain base amounts. The sum of a taxpayer's (1) adjusted gross income, (2) tax-free interest income and (3) one-half of OASDI benefits is compared to a base amount of $25,000 for a single taxpayer, or $32,000 for a married couple filing a joint tax return. If the sum exceeds the base amount, the amount of benefits to be included in taxable income is the lesser of:

(a) one-half of the excess of such sum over the base amount, or

(b) one-half of the amount of benefits received.

The following table contains several examples which illustrate the taxation of Social Security benefits.

EXAMPLES

		A	B	C	D	E
(1)	Type of taxpayer	Single	Single	Couple	Couple	Couple
(2)	Adjusted gross income	$16,000	$23,000	$24,000	$28,000	$50,000
(3)	Tax-free interest income	0	0	0	3,000	2,000
(4)	Social Security	4,000	8,000	3,000	6,000	10,000
(5)	Sum of lines (2) plus (3) plus one-half of (4)	18,000	27,000	25,500	34,000	57,000
(6)	Base amount	25,000	25,000	32,000	32,000	32,000
(7)	Excess amount (line (5) minus (6))	−7,000	2,000	−6,500	2,000	25,000
(8)	Amount of Social Security which is taxed. If line (7) is positive, lesser of one-half of lines (7) or (4). If line (7) is zero or negative, enter 0	0	1,000	0	1,000	5,000

The proceeds from the taxation of Social Security benefits are credited to the OASDI trust funds (see table 12).

For calendar year 1992, CBO projects that 22 percent of Social Security beneficiaries will be affected by the taxation of benefits provision (see table 13).

TABLE 12.—TAXATION OF SOCIAL SECURITY BENEFITS; LIABILITIES INCURRED AS A PERCENT OF TOTAL BENEFIT PAYMENTS

[Dollars in millions]

Fiscal year	Income tax liabilities incurred from the taxation of OASDI benefits	Total OASDI benefits	Income tax liabilities as a percent of total OASDI benefits
Past experience:			
1984	$2,275	$173,603	1.3
1985	3,368	183,959	1.8
1986	3,558	193,869	1.8
1987	3,307	202,430	1.6
1988	3,390	213,907	1.6
1989	3,772	227,150	1.7
1990	3,081	243,275	1.3
Projected: [1]			
1991	4,964	260,819	1.9
1992	5,458	277,996	2.0
1993	5,968	295,968	2.0
1994	6,470	314,387	2.1
1995	7,004	333,412	2.1

[1] Based on alternative II-B assumptions in 1990 Trustees Report.

Note: Income tax liabilities, as shown above for past years, are the actual amounts transferred, on an estimated basis, to the trust funds, and include adjustments for actual experience in prior years.

Source: Office of the Actuary, Social Security Administration.

TABLE 13.—EFFECT OF TAXING SOCIAL SECURITY BENEFITS, BY INCOME CLASS, 1992

[Numbers of persons in thousands; dollars in billions]

Level of individual or couple income [1]	Persons 65 and over			All recipients			Aggregate amount of Social Security benefits	Aggregate amount of taxes on benefits	Taxes as a percent of benefits
	Number	Number affected by taxation [2]	Percent affected by taxation [2]	Number of Social Security beneficiaries [3]	Number affected by taxation [3]	Percent affected by taxation [3]			
Less than $10,000	7,267	0	0	9,583	1	0	51,667	0	0
$10,000 to $15,000	4,113	0	0	4,993	0	0	35,246	0	0
$15,000 to $20,000	3,622	0	0	4,360	2	0	33,290	0	0
$20,000 to $25,000	3,124	0	0	3,691	0	0	26,819	0	0
$25,000 to $30,000	2,576	109	4.2	3,005	149	5.0	23,669	13	0.1
$30,000 to $40,000	3,502	979	27.9	4,131	1,232	29.8	31,774	372	1.2
$40,000 to $50,000	2,433	2,105	86.5	2,742	2,452	89.4	21,569	902	4.6
$50,000 to $100,000	3,079	2,815	91.4	3,401	3,357	96.7	27,491	2,829	10.3
At least $100,000	1,092	899	82.3	937	936	99.8	8,309	1,247	15.0
All	30,809	6,907	22.4	36,844	8,130	22.1	261,837	5,443	2.1

[1] Cash income (based on income of tax filing unit), plus capital gains realizations.

[2] Some elderly individuals do not receive Social Security benefits and are thus not affected by taxation of benefits.

[3] Includes beneficiaries under and over age 65.

Note.—Aggregate benefits and revenues are understated by about 10 percent because of benefits paid abroad, deaths of recipients before March interview, and exclusion of institutionalized beneficiaries. The number of beneficiaries is also understated.

Source: Congressional Budget Office, based on data from the Current Population Survey (CPS).

LEGISLATIVE CHANGES MADE IN THE 97TH CONGRESS

The 97th Congress made numerous changes in the OASDI program. The major changes were included in the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35). Table 14 lists these changes and contains the most recent Congressional Budget Office estimates of their budgetary impact.

TABLE 14.—CONGRESSIONAL BUDGET OFFICE ESTIMATES FOR LEGISLATIVE CHANGES MADE IN OASDI DURING 1981 (JANUARY 1982 ESTIMATES), FISCAL YEARS 1982-84

[In millions of dollars]

	Fiscal year—		
	1982	1983	1984
Elimination of minimum benefit for future beneficiaries	−81	−180	−210
Elimination of benefits for postsecondary students	−567	−1,580	−2,033
Restrictions on payment of lump-sum death benefits	−200	−210	−215
Modification of month of initial entitlement for certain workers and their dependents	−190	−220	−240
Temporary extension of earnings limitation to include all persons aged less than 72	−380	−120	0
Termination of mother's and father's benefits when youngest child attains age 16	−30	−88	−496
Modification of rounding rules	−79	−272	−314
Cost reimbursement for provision of earnings information	−1	−2	−5
Revision of reimbursements for vocational rehabilitation services	−87	−86	−73
Modify worker's compensation offset to: (1) Apply offset to certain other public disability benefits-megacap; (2) apply offset to benefits of workers aged 62 to 64; and (3) begin offset in first month of dual benefit payment	−87	−122	−156
Extension of coverage to first 6 months of sick pay (revenue increase)	−534	−762	−828
Total OASDI	−2,236	−3,642	−4,570

LEGISLATIVE CHANGES MADE IN THE 98TH CONGRESS

The 98th Congress made extensive changes in OASDI programs in the Social Security Amendments of 1983 (Public Law 98-21), enacted to restore the financial status of the Social Security trust funds. Table 15 outlines the estimated outlay and revenues effects of the 1983 amendments under the alternative II-B assumptions of the 1983 Trustees' report. At the time, it was estimated that in the period 1983 through 1989 the OASDI and HI trust funds would receive $166.2 billion and $33.6 billion in additional financing, respectively.

TABLE 15.—ESTIMATED AMOUNTS OF CHANGES IN OASDI RECEIPTS AND BENEFIT PAYMENTS RESULTING FROM THE 1983 SOCIAL SECURITY AMENDMENTS, CY 1983–89

[In billions of dollars]

Provision	Calendar year—							Total, 1983–89
	1983	1984	1985	1986	1987	1988	1989	
Increase tax rate on covered wages and salaries		8.6	0.3			14.5	16.0	39.4
Increase tax rate on covered self-employment earnings		1.1	3.1	3.0	3.2	3.7	4.4	18.5
Cover all Federal elected officials and political appointees		(1)	(1)	(1)	(1)	(1)	(1)	.1
Cover new Federal employees		.2	.7	1.2	1.8	2.4	3.1	9.3
Cover all nonprofit employees		1.3	1.5	1.8	2.1	2.6	3.0	12.4
Total for new coverage		1.5	2.2	3.0	3.9	5.0	6.1	21.8
Prohibit State and local government terminations		.1	2.	.4	6.	8.	1.1	3.2
Accelerate collection of State and local taxes		.6	(1)	(1)	.1	.1	.1	1.0
Modify general fund financing basis for non-contributory military service credits	18.4	−.4	−.4	−.3	−.4	−.4	−.4	16.1
Provide reimbursements from general fund for unnegotiated checks	1.3	.1	.1	.1	.1	.1	.1	1.6
Delay benefit increases 6 months	3.2	5.2	5.4	5.5	6.2	6.7	7.3	39.4
Continue benefits on remarriage		(2)	(2)	(2)	(2)	(2)	(2)	−.1
Modify indexing of deferred survivors' benefits			(2)	(2)	(2)	(2)	(2)	(2)
Raised disabled widow(er)'s benefits to 71.5 percent of PIA		−.2	−.2	−.2	−.2	−.3	−.3	−1.4
Pay divorced spouses whether or not worker has retired			(2)	(2)	(2)	(2)	(2)	−.1
Eliminate "windfall" benefits for individuals receiving pensions from noncovered employment				(3)	(3)	(3)	.1	.1
Offset spouses benefits by up to two-thirds of noncovered Government pension (public pension offset)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Expand use of death certificates to stop benefits	(3)	(3)	(3)	(3)	(3)	(3)	(3)	.1
Impose 5-year residency requirement for certain aliens			(3)	(3)	(3)	(3)	(3)	.1
Tax one-half of benefits for high income beneficiaries		2.6	3.2	3.9	4.7	5.6	6.7	26.6
All other changes	(2)	(2)	(2)	(2)	(2)	(2)	(2)	−.1
Total for all changes	22.8	19.2	13.9	15.3	18.0	35.8	41.2	166.2

[1] New additional taxes of less than $50 million. [2] Additional benefits of less than $50 million. [3] Reduction in benefits of less than $50 million.

Note. Based on 1983 alternative II–B assumptions. Estimates shown for each provision include the effects of interaction with all preceding provisions. Totals do not always equal the sum of components due to rounding. Positive figures represent additional income or reduction in benefits. Negative figures reductions in income or increases in benefits.

Source: Office of the Actuary, Social Security Administration, 1983.

TABLE 16.—ESTIMATED LONG-RANGE OASDI COST EFFECTS OF THE SOCIAL SECURITY AMENDMENTS OF 1983

Provision	Effect as percent of payroll		
	OASI	DI	OASDI
Present law prior to amendments:			
Average cost rate	13.04	1.34	14.38
Average tax rate	10.13	2.17	12.29
Actuarial balance	−2.92	+.83	−2.09
Changes included in titles I and III of the amendments:[1]			
Cover new Federal employees	+.26	+.02	+.28
Cover all nonprofit employees	+.09	+.01	+.10
Prohibit State and local terminations	+.06	+.00	+.06
Delay benefit increases 6 months	+.28	+.03	+.30
Eliminate "windfall" benefits	+.04	+.00	+.04
Raise delayed retirement credits	−.10		−.10
Tax one-half of benefits	+.56	+.05	+.61
Accelerate tax rate increase	+.03		+.03
Increase tax rate on self-employment	+.17	+.02	+.19
Adjust self-employment income	−.02	−.00	−.03
Change DI rate allocation	+.81	−.81	
Continue benefits on remarriage	−.00	−.00	−.00
Pay divorced spouse of nonretired	−.01	−.00	−.01
Modify indexing of survivor's benefits	−.05		−.05
Raise disabled widow's benefits	−.01		−.01
Modify military credits financing	+.01	+.00	+.01
Credit unnegotiated checks	+.00	+.00	+.00
Tax certain salary reduction plans	+.03	+.00	+.03
Modify public pension offset	−.00	−.00	−.00
Suspend auxiliary benefits for certain aliens	+.00	+.00	+.00
Modify earnings test for those aged 65 and over[2]	−.01		−.01
All other provisions of titles I and III	−.00	−.00	−.00
Subtotal for the effect of the above provisions[3]	+2.07	−.68	+1.38
Remaining deficit after the above provisions	−.85	+.15	−.71
Additional change relating to long-term financing (title II):[4] Raise normal retirement age to 67	+.83	−.12	+.71
Total effect of all of the provisions[5]	+2.89	−.80	+2.09

TABLE 16.—ESTIMATED LONG-RANGE OASDI COST EFFECTS OF THE SOCIAL SECURITY AMENDMENTS OF 1983—Continued

Provision	Effect as percent of payroll		
	OASI	DI	OASDI
After the amendments:			
Actuarial balance	−.03	+.03	−.00
Average income rate	11.47	1.42	12.89
Average cost rate	11.50	1.39	12.89

[1] The values of each of the individual provisions listed from title I and title III represent the effect over present law and do not take into account interaction with other provisions with the exception of the provision relating to the earnings test.

[2] Estimates from modifying the earnings test take into account interaction with the provision raising delayed retirement credits.

[3] The values in the subtotal for all provisions included in title I and title III take into account the estimated interactions among these provisions.

[4] The values for each of the provisions of title II take into account interaction with the provisions included in title I and title III.

[5] The values for the total effect of the amendments take into account interactions among all of the provisions.

Source: Social Security Bulletin, July 1983. The above estimates are based on preliminary 1983 Trustees' Report Alternative II–B assumptions. Individual estimates may not add to totals due to rounding and/or interaction among proposals.

LEGISLATIVE CHANGES MADE IN THE 99TH CONGRESS

Several legislative changes were made in the Social Security program in the 99th Congress. The Consolidated Omnibus Reconciliation Act of 1985 (Public Law 99–272) included a variety of minor and technical legislative changes in Social Security. Additionally, Public Law 99–272 contained provisions to: (a) exempt wages paid retired Federal judges performing active duty for the purposes of the FICA taxation and the Social Security earnings limitation; and (b) to protect certain Social Security beneficiaries who receive overpayments through the electronic direct deposit system.

The Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509) included two significant Social Security provisions. The first eliminated the requirement that the annual rise in the Consumer Price Index must exceed 3 percent in order for a cost-of-living adjustment to be paid to Social Security beneficiaries. Under the new law, a cost-of-living adjustment will be paid in any year in which there is a measurable increase in consumer inflation. Secondly, Public Law 99–509 removed from the States the responsibility for collecting and depositing with the Federal Government Social Security contributions on behalf of their political subdivisions. All State and local entities now deposit their Social Security contributions directly to the Federal Government on a time schedule that parallels the treatment of private employers.

The Emergency Deficit Reduction and Balanced Budget Act of 1985 (Public Law 99–177) contained a provision to remove the receipts and disbursements of the Social Security trust funds from the unified budget effective in fiscal year 1986, and to restrict consideration of legislative changes in Social Security as part of the congressional budget process. The new law contained measures to bring the Federal budget into balance by fiscal year 1991. Under it, Social Security income and outgo are used in calculating the Federal deficit, but benefits are exempt from any automatic cuts required to reduce the deficit. Moreover, the act contained provisions making it difficult for Social Security changes to be brought up in the congressional budget process by permitting the raising of "points of order" against such measures.

LEGISLATIVE CHANGES MADE IN THE 100TH CONGRESS

Extend FICA tax to certain earnings.—

Armed Services reservists.—FICA taxes were extended to "inactive duty training" (generally weekend training drill sessions).

Agricultural workers.—Wages paid to an employee who received less than $150 in annual cash remuneration by an agricultural employer were exempted from FICA tax even if the employer paid more than $2,500 in the year to all employees, provided the employee: (1) is a hand harvest laborer and is paid on a piece-rate basis in an operation which has been customarily recognized as having been paid on a piece-rate basis in the region of employment, (2) commutes daily from his or her permanent residence, and (3) has been employed in agriculture less than 13 weeks during the preceding calendar year.

Individuals aged 18-21.—FICA taxes were extended to services performed by individuals between the ages of 18 and 21 who are employed in their parent's trade or business.

Spouses.—FICA taxes were extended to services performed by an individual in the employ of his or her spouse's trade or business.

Tips.—The employer's share of FICA taxes was extended to include all cash tips (up to the Social Security wage base).

Phase-out of reduction in windfall benefits.—The phase-out of the reduction of benefits for workers with noncovered pensions was changed from 25 to 30 years of Social Security coverage to 20 to 30 years.

Treatment of group-term life insurance wages under FICA.—Employer-provided group-term life insurance was included in wages for FICA tax purposes if such insurance were includable for gross income tax purposes, effective January 1, 1988.

Correction in government pension offset.—Federal employees who switch from the Civil Service Retirement System (CSRS) to the Federal Employees' Retirement System (FERS) on or after January 1, 1988 were exempted from the government pension offset only if they had 5 or more years of Federal employment covered by Social Security after December 31, 1987.

Continuation of disability benefits pending appeal.—The existing provision for continued payment of disability benefits during the administrative appeal process was extended through 1989.

Lengthening the extended period of eligibility for disability benefits.—The extended period of eligibility during which a disability beneficiary who returns to work may become automatically reentitled to benefits was lengthened from the current 15 months to 36 months. Medicare eligibility is not continued beyond the period provided under current law.

Payment of attorneys' fees.—The administrative policy which permits administrative law judges to authorize attorneys' fees of up to $3,000 without approval by an SSA regional office was reinstated.

LEGISLATIVE CHANGES MADE IN THE 101ST CONGRESS

Continuation of disability benefits during appeal.—The provision of current law permitting disability insurance beneficiaries to elect to have their benefits continued during appeal was made permanent.

Payment of benefits to a child adopted after a parent's entitlement to retirement or disability benefits or adopted by a surviving spouse.—A child adopted after a worker became entitled to retirement or disability benefits was made eligible for child's insurance benefits regardless of whether he or she was living with and dependent on the worker prior to the worker's entitlement. A child adopted by the surviving spouse of a deceased worker was made eligible for benefits regardless of whether he or she had been receiving support from anyone other than the worker and the worker's spouse, as long as the child either lived with the worker or received one-half support from the worker in the year preceding the worker's death.

Repeal of carryover reduction in retirement or disability insurance benefits due to receipt of widow(er)'s benefits before age 62.—The carryover reduction applied to retirement or disability benefits received by widow(er)s who collected widow(er)'s benefits before age 62 was eliminated.

Improvements in Social Security Administration services and beneficiary protections.—A number of improvements were made in SSA procedures regarding correction of earnings records; standards applicable in determinations of fault, good faith and good cause; same-day interviews on time-sensitive matters; notices sent to blind Social Security beneficiaries; legal representatives of claimants; and the avenues of recourse open to potential applicants who lose benefits because SSA provides them with inaccurate or incomplete information. In addition, SSA was required to issue a report on options for increasing its use of foreign language notices. Conforming changes were also made in the Supplemental Security Income program as applicable.

Earnings and benefit statements.—SSA was required, upon request, to provide individuals with a statement of their earnings and contributions and an estimate of their future benefits. Beginning in 1995, these statements will be provided to all individuals who attain age 60. Beginning in October 1999, these statements will be provided annually to all workers covered under Social Security.

Inclusion of certain deferred compensation in the calculation of average wages under the Social Security Act.—Contributions to deferred compensation plans, including amounts deferred in 401(k) plans, were included in the determination of average wages for Social Security purposes.

Treatment of refunds by employers under the Medicare Catastrophic Coverage Act of 1988 for FICA and other purposes.—Refunds provided to individuals by employers under the maintenance-of-effort provision of the Medicare Catastrophic Coverage Act of 1988 were excluded from wages for FICA, FUTA, and railroad retirement and railroad unemployment insurance tax purposes. In addition, the Secretary of the Treasury was given authority to prescribe the manner in which the refunds were to be reported.

Extension of Social Security coverage exemption for members of certain religious faiths.—The exemption from Social Security coverage for workers who are members of certain religious groups was extended to: (a) qualifying employees of partnerships in which each partner holds a religious exemption from Social Security coverage, and (b) qualifying employees of churches and church-controlled non-profit organizations who would otherwise be covered as self-employed for purposes of Social Security taxation.

Prohibition against termination of coverage of U.S. citizens and residents employed abroad by a foreign affiliate of an American employer.—American employers were prohibited from terminating the Social Security coverage of U.S. citizens and residents employed abroad in their foreign affiliates.

Extension of disability insurance program demonstration project authority.—The authority of the Secretary of HHS to conduct work incentive demonstration projects was extended for three additional years.

Inclusion of employer cost of group-term life insurance in compensation under the Railroad Retirement Tax Act.—Employer-paid premiums for group-term life insurance coverage in excess of $50,000 were made subject to the railroad retirement payroll tax, bringing the treatment of such premiums into conformity with their treatment under the Social Security Act.

Inclusion of deferred compensation arrangements, including 401(k) plans, in compensation under the Railroad Retirement Tax Act.—Contributions to 401(k) deferred compensation plans were made subject to the railroad retirement payroll tax, bringing the treatment of such contributions into conformity with their treatment under the Social Security Act.

Codification of the Rowan *decision with respect to railroad retirement.*—Except for meals and lodging provided for the convenience of the employer, it was stipulated that nothing in Internal Revenue Service (IRS) regulations defining wages for purposes of the income tax is to be construed as requiring a similar definition for purposes of the railroad retirement payroll tax, thus conforming the Railroad Retirement Tax Act to the Social Security Act.

Extension of general fund transfers to railroad retirement tier II trust fund.—The transfer of proceeds from the income taxation of railroad retirement Tier II benefits from the general fund of the Treasury to the railroad retirement trust fund was extended to October 1, 1992.

Social Security coverage of State and local employees not covered by a public retirement system.—Employees of State and local governments (excluding students who are employed by public schools, colleges or universities) who are not covered by a public retirement system were covered by Social Security and Medicare (i.e., Old-Age, Survivors, and Disability Insurance (OASDI) and Hospital Insurance (HI); the provision is effective after July 1, 1991.

Budgetary treatment of Social Security trust funds.—The Social Security trust funds (OASDI Trust Funds) were removed from the calculation of the deficit under the Gramm-Rudman-Hollings law beginning with fiscal year 1991; thus, Social Security was taken "off budget." The trust funds were protected by points of order in the House and Senate against legislation which would reduce trust fund balances.

Improvement of the definition of disability applied to disabled widow(er)s.—The stricter definition of disability that was previously applied only to widow(er)s was repealed. Instead, a disabled widow(er) is subject to the same definition of disability as is already applied to disabled workers.

Improvements in the OASDI and supplemental security income (SSI) representative payee system.—The representative payee system was improved by: (a) requiring the Secretary of Health and Human Services (the Secretary) to conduct a more extensive investigation of the representative payee applicant; (b) providing stricter standards in determining the fitness of the representative payee applicant to manage benefit payments on behalf of the beneficiary; and (c) directing the Social Security Administration to make recommendations regarding the application of stricter accounting procedures to certain high-risk representative payees.

In addition, certain community-based nonprofit social service agencies providing representative payee services of last resort were allowed to collect a fee from an individual's Social Security or SSI benefit for expenses incurred in providing such services.

Streamlining of the attorney fee payment process.—The process by which SSA reviews and approves any fee charged by an attorney representating a claimant before the agency was reformed. The current fee petition process was generally replaced by a streamlined procedure under which fees are paid up to a limit of 25 percent of past-due benefits not to exceed $4,000, unless the attorney, claimant, or administrative law judge objects. The fee petition was retained in cases for which the fee requested exceeds the limits, or if the determination made on the claim is not favorable.

Improvements in SSA services and beneficiary protections.—The Secretary was required to carry out a demonstration to test ways to improve procedures for providing service by telephone. In addition, when a claimant who is denied benefits reapplies, rather than appealing, based on inaccurate or misleading information from SSA, the failure to appeal would not constitute a basis for denial of the second application. New requirements were also established for improvements in notices regarding title II and title XVI benefits.

Restoration of telephone access to the local offices of SSA.—SSA was required to reestablish telephone access to its local offices at the level generally available on September 30, 1989, the day before it established a national 800 number and cut off most of its local office telephones.

Creation of a rolling 5-year trial work period for all disabled beneficiaries.—Effective January 1, 1992, the current trial work period will be liberalized so that a disabled beneficiary will exhaust this period only after completing 9 trial work months in any rolling 60-month period. In addition, beneficiaries will receive a new trial work period for each period of eligibility.

Continuation of benefits on account of participation in a non-State vocational rehabilitation program.—Beneficiaries who medically recover while participating in an approved non-State vocational rehabilitation program were granted the same benefit continuation rights as those who medically recover while participating in a State-sponsored program.

Limitation on new entitlement to special age-72 payments.—The provision precluded the unintended payment of so-called "Prouty benefits," which were enacted in 1966 to help workers who were too old to earn sufficient quarters of coverage to qualify for regular benefits. Because of subsequent amendments to the law, it was theoretically possible for some workers to qualify for Prouty benefits after 1990, even though, when enacted, they were not expected to be paid to anyone who reached age 72 after 1971.

Elimination of advance tax transfer.—The Social Security trust funds were credited with tax receipts as they were collected throughout the month, rather than in advance (at the first of the month), as under previously existing law. However, the advance tax-transfer mechanism (enacted to help meet the Social Security funding emergency that existed prior to the 1983 amendments) was retained as a contingency to be used if the trust funds drop to such a low level that it is needed in order to pay current benefits.

Repeal of retroactive benefits for certain categories of individuals.—Retroactive benefits were eliminated for two categories of individuals eligible for reduced benefits: (a) those with dependents entitled to unreduced benefits, and (b) those with preretirement earnings over the amount allowed under the retirement test who had used the retroactive benefits to charge off their excess earnings.

Consolidation of old computation methods.—A number of little-used, pre-1968 benefit computation formulas were eliminated.

Suspension of dependents' benefits when a disabled worker is in an extended period of eligibility.—Current SSA practice regarding the nonpayment of benefits to a disabled worker's dependents when that worker is in an extended period of eligibility and is not receiving monthly Social Security benefits was codified.

Payment of benefits to a deemed spouse and a legal spouse.—Eligibility requirements for payment of benefits to a "deemed spouse"—a spouse whose marriage is found to be invalid—were changed so that the entitlement of the worker's legal spouse would no longer terminate payment of benefits to a deemed spouse.

Creation of a vocational rehabilitation demonstration project.—SSA was required to carry out a demonstration project testing the advantages and disadvantages of permitting disabled Social Security beneficiaries to select a qualified vocational rehabilitation provider, either public or private, from which to receive services aimed at enabling them to obtain work and leave the disability rolls.

Use of Social Security number by certain legalized aliens.—Certain aliens who were granted amnesty under the provisions of the Immigration Reform and Control Act of 1986 were exempted from criminal penalties for fraudulent use of a Social Security card. The exemption did not apply to those individuals who sold Social Security cards, possessed cards with intent to sell, or counterfeited or possessed counterfeited cards with the intent to sell.

Reduction in amount of wages needed to earn a year of coverage toward the special minimum benefit.—Effective in 1991, the amount of earnings needed to earn a year of coverage toward the special minimum benefit (designed to assist long-term, low-wage workers) was reduced from 25 percent of the "old law" contribution and benefit base ($9,900 in 1991), to 15 percent of the base ($5,940 in 1991).

Charging of earnings of corporate directors.—A provision of previous law that treated a corporate director's earnings as taxable when the services to which they are attributable were performed was repealed. A director's earnings continue to be treated as received when the services are performed for purposes of the Social Security retirement test.

Collection of employee Social Security tax on group-term life insurance.—In cases where an employer continues to provide taxable group-term life insurance to an individual who has left his employment, the former employee was required to pay the employee portion of the Social Security tax directly.

Waiver of the 2-year waiting period for certain divorced spouses.—The 2-year waiting period for independent entitlement to divorced spouse benefits was waived in cases where the worker was entitled to benefits prior to the divorce.

Preeffectuation review of favorable decisions by the Social Security Administration.—The percentage of favorable decisions made by State disability determination services that must be reviewed by SSA was reduced from 65 percent of all such decisions to 50 percent of allowances and as many continuances as are required to maintain a high level of accuracy in such decisions. The reviews are to be targeted on those cases most likely to contain errors.

Recovery of overpayments from former Social Security beneficiaries through tax refund offset.—SSA was permitted to recover overpayments from former beneficiaries through arrangements with the Internal Revenue Service (IRS) to offset the former beneficiary's tax refund. This authority will remain in effect so long as the existing governmentwide offset program remains in effect (currently, until January 10, 1994).

CHARACTERISTICS OF BENEFICIARY POPULATION

Tables 17 through 19 provide detailed information on the numbers of various OASDI beneficiaries, the average amount of monthly benefits by type of beneficiary for new awards and for all beneficiaries currently receiving payments. More detailed information is shown in table 18 for December 1988.

TABLE 17.—OASI CASH BENEFITS: AVERAGE AMOUNT OF MONTHLY BENEFITS BY TYPE AND NUMBER OF BENEFICIARIES, CURRENT PAYMENT STATUS, DECEMBER 1990, AND NEW AWARDS, 1990

	Current payment		New awards	
	Number (in thousands)	Average payment	Number (in thousands)	Average payment
Retired workers	24,838	$503	1,665	$579
Wives and husbands of retired workers	3,101	311	309	285
Children of retired workers	422	259	108	248
Surviving children	1,776	406	304	403
Widowed mothers and fathers	304	409	58	398
Widows and widowers	5,010	556	436	560
Disabled widow(er)s	101	389	15	400
Parents	6	482	(1)	512

[1] Less than 500.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 18.—NUMBER OF PERSONS RECEIVING VARIOUS TYPES OF OASDI BENEFITS BY AGE, SEX, AND AVERAGE MONTHLY BENEFIT AMOUNTS, DECEMBER 1989

[Based on 10-percent sample]

Benefits by age and sex	Number (thousands)	Percent of total beneficiaries	Average monthly benefit	Percentage of total benefits
Retired workers:				
Men:				
62 to 64	1,330	3.4	$587	3.9
65 to 69	3,841	9.8	611	11.7
70 to 79	5,460	14.0	683	18.6
80 to 89	1,863	4.8	614	5.7
90 and over	224	.6	551	.6
Total, retired men	12,717	32.5	639	40.6
Women:				
62 to 64	1,180	3.0	371	2.2
65 to 69	3,018	7.7	437	6.6
70 to 79	4,824	12.3	531	12.8
80 to 89	2,196	5.6	530	5.8
90 and over	379	1.0	466	.9
Total, retired women	11,598	29.6	488	28.3
Total, retired workers	24,314	62.2	567	68.8

TABLE 18.—NUMBER OF PERSONS RECEIVING VARIOUS TYPES OF OASDI BENEFITS BY AGE, SEX, AND AVERAGE MONTHLY BENEFIT AMOUNTS, DECEMBER 1989—Continued

[Based on 10-percent sample]

Benefits by age and sex	Number (thousands)	Percent of total beneficiaries	Average monthly benefit	Percentage of total benefits
Disabled workers:				
Men:				
Under 50	744	1.9	564	2.1
50 to 59	611	1.6	646	2.0
60 to 61	198	.5	646	.6
62 to 64	346	.9	660	1.1
Total, disabled men	1,899	4.9	617	5.8
Women:				
Under 50	369	.9	461	.8
50 to 59	331	.8	430	.7
60 to 61	108	.3	414	.2
62 to 64	180	.5	428	.4
Total, disabled women	988	2.5	439	2.9
Total, disabled workers	2,887	7.4	556	8.0
Wives of retired workers:				
With entitled children:				
Under 35	5	(1)	155	(1)
35 to 44	19	(1)	168	(1)
45 to 54	31	.1	186	(1)
55 to 64	33	.1	220	(1)
Total, with entitled children	88	.2	193	.1
Without entitled children: 62 and over	2,975	7.6	297	4.4
Total, wives of retired workers	3,063	7.8	294	4.5
Total, husbands of retired workers	31	.1	192	(1)
Total, spouses of retired workers	3,094	7.9	293	4.5
Wives of disabled workers:				
With entitled children:				
Under 35	52	.1	101	(1)
35 to 44	90	.2	130	.1
45 to 54	44	.1	152	(1)
55 to 64	11	(1)	175	(1)
Total, with entitled children	197	.5	130	.1
Without entitled children: 62 and over	66	.2	193	.1
Total, wives of disabled workers	263	.7	146	.2
Total, husbands of disabled workers	6	(1)	97	(1)
Total, spouses of disabled workers	270	.7	145	.2

TABLE 18.—NUMBER OF PERSONS RECEIVING VARIOUS TYPES OF OASDI BENEFITS BY AGE, SEX, AND AVERAGE MONTHLY BENEFIT AMOUNTS, DECEMBER 1989—Continued

[Based on 10-percent sample]

Benefits by age and sex	Number (thousands)	Percent of total beneficiaries	Average monthly benefit	Percentage of total benefits
Children:				
Children of retired workers:				
0 to 6	21	.1	182	(1)
7 to 10	36	.1	187	(1)
11 to 17	181	.5	224	.2
18 to 19 (students)	12	(1)	287	(1)
Disabled children 18 and over to	173	.4	280	.2
Total, children of retired workers	422	1.1	243	.5
Children of deceased workers:				
0 to 6	151	.4	341	.3
7 to 10	269	.7	352	.5
11 to 17	927	2.4	401	1.9
18 to 19 (students)	55	.1	446	.1
Disabled children 18 and over	382	1.0	379	.7
Total, children of deceased workers	1,784	4.6	385	3.4
Children of disabled workers:				
0 to 6	147	.4	123	.1
7 to 10	196	.5	128	.1
11 to 17	558	1.4	168	.5
18 to 19 (student)	23	.1	243	(1)
Disabled children 18 and over	36	.1	221	(1)
Total, children of disabled workers	961	2.5	157	.7
Total, children	3,167	8.1	297	4.7
Widowed mothers and fathers:				
Under 30	32	.1	345	.1
30 to 39	121	.3	374	.2
40 to 49	102	.3	404	.2
50 to 59	43	.1	414	.1
60 to 61	6	(1)	414	(1)
62 and over	9	(1)	416	(1)
Total, widowed mothers and fathers	313	.8	388	.6
Widows (nondisabled):				
60 to 61	165	.4	488	.4
62 to 64	435	1.1	499	1.1
65 to 69	927	2.4	532	2.5
70 to 79	1,776	4.5	535	4.7

TABLE 18.—NUMBER OF PERSONS RECEIVING VARIOUS TYPES OF OASDI BENEFITS BY AGE, SEX, AND AVERAGE MONTHLY BENEFIT AMOUNTS, DECEMBER 1989—Continued

[Based on 10-percent sample]

Benefits by age and sex	Number (thousands)	Percent of total beneficiaries	Average monthly benefit	Percentage of total benefits
80 to 89	1,293	3.3	522	3.4
90 and over	326	.8	486	.8
Total, widows	4,922	12.6	523	12.9
Widowers (nondisabled):				
60 to 61	5	(1)	328	(1)
62 to 64	9	(1)	414	(1)
65 to 69	6	(1)	434	(1)
70 to 74	3	(1)	398	(1)
75 to 79	3	(1)	357	(1)
80 to 84	3	(1)	365	(1)
85 and over	3	(1)	355	(1)
Total, widowers	33	.1	386	.1
Disabled widows and widowers:				
50 to 54	13	(1)	370	(1)
55 to 59	37	.1	367	.1
60	11	(1)	366	(1)
61	11	(1)	367	(1)
62	11	(1)	365	(1)
63	11	(1)	358	(1)
64	10	(1)	366	(1)
Total, disabled widows and widowers	103	.3	366	.2
Disabled widows	101	.3	368	.2
Disabled widowers	2	(1)	229	(1)
Parents: Total	6	(1)	456	(1)
Special age 72 beneficiaries (primary):				
Men	1	(1)	158	(1)
Women	9	(1)	158	(1)
Total special age 72 beneficiaries	10	(1)	158	(1)
Total OASI beneficiaries	35,001	89.5	521	91.0
Total DI beneficiaries	4,117	10.5	436	9.0
Total	39,118	100.0	512	100.0

[1] Less than 0.1 percent.

Note.—Columns may not add due to rounding.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 19.—NUMBER OF SOCIAL SECURITY RETIRED-WORKER NEW BENEFIT AWARDS AND PERCENT RECEIVING REDUCED BENEFITS BECAUSE OF ENTITLEMENT BEFORE AGE 65, AS OF DECEMBER OF GIVEN YEAR

[Number in millions]

Year [1]	Total		Men		Women	
	Number	Percent	Number	Percent	Number	Percent
1956	0.9	12	0.6	([2])	0.4	31
1960	1.0	21	.6	([2])	.4	60
1965	1.2	49	.7	43	.4	60
1970	1.3	63	.8	57	.5	72
1975	1.5	73	.9	69	.6	79
1980	1.6	76	.9	73	.7	80
1985	1.7	74	1.0	70	.7	79
1986	1.7	74	1.0	71	.7	79
1987	1.7	74	1.0	71	.7	79
1988	1.6	74	.9	70	.7	78
1989	1.7	73	1.0	69	.7	78
1990	1.7	74	1.0	71	.7	78

[1] Data for 1985–90 based on a 1-percent sample; data for earlier years based on 100 percent.

[2] Reduced Benefits were not available to men until 1961. They were not available to women until 1956.

Source: Office of Research and Statistics, Social Security Administration.

The previous three tables have shown the number and average benefit classified by type of beneficiary and the percent who retire early. Many individuals receive benefits on their own record plus other benefits based upon earnings of their spouse or former spouse. Table 20 separates, by type of female beneficiary, the amount of benefits received on her own earnings record versus someone else's. As of December 1990, 10.7 million female beneficiaries over age 64 were insured and received an average benefit of $532 or total benefits of $5.7 billion. Some 7.0 million female beneficiaries over age 64 who were not insured received an average benefit of $471. These benefits were all earned by a spouse or former spouse. Most of these benefits represent a survivor benefit. Table 21 presents similar information for male beneficiaries.

TABLE 20.—OASDI MONTHLY BENEFITS RECEIVED BY FEMALES, DECEMBER 1990 [1]

[Numbers in thousands; amounts in millions except averages]

	Total OASDI benefit	Based on own earnings record		Benefit received as				Percent of total female benefits
				Dependent spouse			Mother, parent, or special primary	
		Old-age	Disability	Retirement	Survivor	Disability		
Age 65 and over (insured): Number	10,690	10,690	(2)	[2] 1,683	2,627	(2)	1	
Total benefits	$5,688	$4,685		$223	$779		(3)	53.5
Average	$532	$438		$133	$297		$270	
Age 65 and over (not insured): Number	6,985			2,551	4,391	29	13	
Total benefits	$3,289			$815	$2,464	$6	$4	31.1
Average	$471			$320	$561	$204	$312	
Age 62 to 64 (insured): Number	1,348	1,165	[2] 183	[2] 352	29		(2 4)	
Total benefits	$541	$405	$82	$43	$11		(3)	5.1
Average	$401	$347	$448	$123	$369		$340	
Age 62 to 64 (not insured): Number	940			443	453	36	8	
Total benefits	$376			$128	$237	$7	$4	3.6
Average	$401			$290	$524	$205	$456	
Age less than 62: Number	1,643		861	76	232	194	280	
Total benefits	$672		$403	$15	$112	$26	$116	6.4
Average	$409		$468	$201	$482	$133	$416	
Total: Number	21,604	11,854	1,044	3,070	5,076	259	301	
Benefits	$10,567	$5,090	$485	$1,225	$3,603	$39	$124	100.0
Average	$489	$429	$464	$399	$710	$151	$414	
Percent of total female benefits	100.0	48.2	4.6	11.6	34.1	0.4	1.2	

---

[1] Table does not include female child beneficiaries. [2] Dually entitled. [3] Less than $500,000. [4] Less than 500.

TABLE 21.—OASDI MONTHLY BENEFITS RECEIVED BY MALES, DECEMBER 1990 [1]

[Numbers in thousands; amounts in millions except averages]

	Total OASDI benefits	Based on own earnings record		Benefit received as				Percent of total male benefits
				Dependent spouse			Father, parent, or special primary	
		Old-age	Disability	Retirement	Survivor	Disability		
Age 65 and over (insured): Number	11,650	11,650		(2)	(2)		(2)	
Total benefits	$7,989	$7,989		(2)	(2)		(2)	78.9
Average	$686	$686						
Age 65 and over (not insured): Number	52			30	20	1	1	
Total benefits	$15			$6	$8	(3)	(3)	.1
Average	$280			$200	$4,104	$121	$289	
Age 62 to 64 (insured): Number	1,682	1,334	348	(2)	(2)		(2)	
Total benefits	$1,075	$830	$245	(2)	(2)		(2)	10.6
Average	$639	$623	$702					
Age 62 to 64 (not insured): Number	10			1	9	(4)	(4)	
Total benefits	$4			(3)	$4	(3)	(3)	(5)
Average	$394			$153	$431	$108	$307	
Age less than 62: Number	1,646		1,619	(4)	7	5	15	
Total benefits	$1,046		$1,039	(3)	$2	(3)	$4	10.3
Average	$635		$642	$107	$334	$91	$264	
Total: Number	15,041	12,984	1,967	31	36	6	16	
Benefits	$10,129	$8,820	$1,284	$6	$14	$1	$4	100.0
Average	$673	$679	$652	$198	$401	$97	$266	
Percent of total male benefits	100.0	87.1	12.7	.1	.1	(5)	(5)	

---

[1] Table does not include male child beneficiaries. [2] Dually-entitled. [3] Less than $500,000. [4] Less than 500. [5] Less than 0.05 percent.

Source: Office of the Actuary, Social Security Administration.

TABLE 22.—1991 SUMMARY SOCIAL SECURITY INFORMATION

Tax rate:	
Employee and employer each	7.65 percent (6.20 percent—OASDI, 1.45 percent—HI).
Self-employed	15.30 percent (12.40 percent—OASDI, 2.9 percent—HI).
OASDI contribution and benefit base	$53,400.
HI earnings base	$125,000.
Earnings required for a quarter of coverage	$540 equals 1 QC.
Retirement test exempt earnings limits:	
Age 65 to 69	$9,720 annual, $810 monthly.
Under age 65	$7,080 annual, $590 monthly.

Bend points:

PIA	Maximum Family Benefit
90 percent of first $370 of AIME, plus 32 percent of AIME over $370 through $2,230, plus 15 percent of AIME over $2,230.	150 percent of first $473 of PIA, plus 272 percent of PIA over $473 through $682, plus 134 percent of PIA over $682 through $890, plus 175 percent of PIA over $890.

	January 1991 PIA amount	Replacement rate (percent)
Benefit examples for worker retiring in 1991 at age 65:		
Low earner [1]	$461.20	58.3
Average earner [2]	751.10	42.7
Maximum earner [3]	1,022.90	24.0

---

[1] Earnings 45 percent of average wages.

[2] Average earning level: 1989, $20,099.55; 1990 (est.) $21,179.

[3] Earnings equal to the maximum earnings taxable for OASDI program: 1989, $48,000; 1990, $51,300.

Source: Office of the Actuary, Social Security Administration.

TABLE 23.—JANUARY 1991 MONTHLY BENEFIT AMOUNTS FOR SELECTED BENEFICIARY FAMILIES WITH FIRST ELIGIBILITY IN 1990

Beneficiary family	Worker with yearly earnings equal to—				
	Federal minimum wage [1]	75 percent of average wage	Average wage [2]	150 percent of average wage	Maximum taxable earnings [3]
RETIRED WORKER FAMILIES [4]					
Average indexed monthly earnings	$839.00	$1,209.00	$1,613.00	$2,205.00	$2,648.00
Primary insurance amount	505.50	625.30	761.60	950.40	1,020.50
Maximum family benefit	776.30	1,115.70	1,389,50	1,662.40	1,785.10
Monthly benefit amount:					
Retired worker, at age 62 [4]					
Worker alone	400.00	500.00	609.00	760.00	816.00
Worker with spouse claiming benefits at—					
Age 65 or older	650.00	812.00	989.00	1,235.00	1,326.00
Age 62 [4]	587.00	734.00	894.00	1,116.00	1,198.00
SURVIVOR FAMILIES [5]					
Average indexed monthly earnings	$785.00	$1,212.00	$1,616.00	$2,424.00	$3,527.00
Primary insurance amount	482.30	626.30	762.60	985.10	1,159.50
Maximum family benefit	726.70	1,118.60	1,391.00	1,723.10	2,028.20
Monthly benefit amount:					
Survivors of worker deceased at age 40 [5]—					
1 surviving child	361.00	469.00	571.00	738.00	869.00
Widowed mother or father and 1 child	722.00	938.00	1,142.00	1,476.00	1,738.00
Widowed mother or father and 2 children	726.00	1,116.00	1,389.00	1,722.00	2,028.00
DISABLED WORKER FAMILIES [6]					
Average indexed monthly earnings	$831.00	$1,210.00	$1,613.00	$2,334.00	$2,989.00
Primary insurance amount	497.70	625.60	761.60	970.90	1,074.40
Disability maximum family benefit [7]	744.40	938.40	1,142.40	1,456.40	1,611.60
Monthly benefit amount:					
Disabled worker age 50 [6]—					
Worker alone	497.00	625.00	761.00	970.00	1,074.00
Worker, spouse, and 1 child	743.00	937.00	1,141.00	1,454.00	1,610.00

---

[1] Worker earned the Federal minimum wage and worked 2,080 hours per year in all years used in the computation of the benefit.

[2] Worker earned the national average wage in each year used in the computation of the benefit.

[3] Worker earned the maximum amount of wages that can be credited to a worker's Social Security record in all years used in the computation of the benefit.

[4] Assumes the worker retired at age 62 in 1990 and had no prior period of disability.

[5] Assumes the deceased worker began to work at age 22, was deceased in 1990 at age 40, had no earnings in that year, and had no prior period of disability.

[6] Assumes the worker began to work at age 22, became disabled in 1990 at age 50, and had no prior period of disability.

[7] The 1980 Amendments to the Social Security Act provide for a different family maximum amount for disability cases. For disabled workers entitled after June 1980, the maximum is the smaller of (1) 85 percent of the worker's AIME (or 100 percent of the PIA, if larger) or (2) 150 percent of the PIA.

Source: Office of Research and Statistics, Social Security Administration.

Section 2. Disability Insurance Program

The disability insurance (DI) program provides monthly cash benefits for disabled workers under age 65 and their dependents. Benefits for the disabled were provided to disabled workers age 50 or older by the 1956 Social Security Amendments; benefits for their dependents were provided by the 1958 Social Security Amendments. Benefits to disabled workers under age 50 were provided by the 1960 amendments.

GENERAL

Many provisions of the DI program are identical to those of the OASI program. For example, all workers who are covered by OASI are also covered by DI. Contributions are made under the same provision of the Internal Revenue Code and are made on the same wage base.

The DI portion of the OASDI tax is allocated to the Disability Insurance Trust Fund, which is the source of payment for monthly benefits to disabled workers and their dependents and for administrative expenses of the program. In addition, the revenue derived from the taxation of disability benefits is credited to the trust fund.

The purpose of both OASI and DI benefits is to replace income lost when the wage-earner is no longer able to work. However, significant differences exist between the two programs, primarily because of the different nature of the event insured. The OASI program insures a worker, his dependents and survivors against loss of income due to the worker's retirement or death. The DI program insures against the loss of income due to the worker's physical or mental disability. In addition, the OASI program is administered solely by Federal employees in Federal installations, whereas the DI program is administered both through Federal Social Security offices and State disability determination services staffed by State employees.

BENEFITS

Summary

Monthly cash benefits are paid and computed generally on the same basis as in the OASI program. Benefit amounts are related to the past earnings of the insured worker.

In December 1990 there were 4.3 million DI beneficiaries in current-payment status. The total monthly benefits paid out were $2.0 billion. Table 1 summarizes various types of beneficiaries of the DI program currently receiving benefits, and average benefit amounts and the number of new awards during 1990.

TABLE 1.—DISABILITY CASH BENEFITS: NUMBER IN CURRENT PAYMENT STATUS AND AVERAGE BENEFIT AMOUNT (DECEMBER 1990) AND NUMBER OF BENEFITS AWARDED DURING THE YEAR AND AVERAGE BENEFIT AMOUNT, 1990

	Current payment		New awards	
	Number (in thousands)	Average payment	Number (in thousands)	Average payment
Disabled workers	3,011	$587	468	$598
Wives and husbands of workers	266	150	70	151
Children of disabled workers	989	164	284	154

Source: Office of Research and Statistics, Social Security Administration.

Description of major benefit types

Disabled-worker benefit.—A monthly benefit payable to a disabled worker under age 65 insured for disability.

Spouses' benefit.—Monthly benefit payable to a spouse or divorced spouse of a disabled worker under one of the following conditions: (1) wife or husband (a) is aged 62 or older, or (b) has 1 or more entitled children of the worker who is disabled or under age 16 in his or her care; or (2) divorced wife (husband) is aged 62 or older and her (his) marriage to worker lasted 10 years (20 years for benefits paid or applications filed before January 1979) before divorce became final.

Child's benefit.—A monthly benefit payable to an unmarried child or eligible grandchild of a disabled worker.

Disabled child's benefit.—A monthly benefit payable to a disabled person aged 18 or over—a dependent son or daughter or eligible grandson or granddaughter of a retired, deceased, or disabled worker—whose disability began before age 22.

Disabled widow (or widower).—A monthly benefit payable to a disabled widow(er) age 50–59.

Definition of disability

Generally, disability is defined as an inability to engage in any substantial gainful activity by reason of a physical or mental impairment. The impairment must be medically determinable and expected to last for not less than 12 months or to result in death. A person may be determined to be disabled only if due to this impairment he is unable to engage in any kind of substantial gainful work, considering his age, education, and work experience, which exists in the national economy even though such work does not exist in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

There is a special definition and eligibility requirements for persons who are blind.

Waiting period

An initial 5-month waiting period is required before DI benefits will be paid. Benefits are payable for the 6th month. However, benefits may be paid for the 1st full month of disability to a worker who becomes disabled within 60 months (for a disabled widow or widower the period is 84 months) after termination of DI benefits from an earlier period of disability.

Insured status

Workers are *insured for disability* if they are fully insured and, except for persons who are blind or disabled before age 31, have a total of at least 20 quarters of coverage during the 40-quarter period ending with the quarter in which the worker became disabled. Workers who are disabled before age 31 must have total quarters of coverage equal to half the calendar quarters which have elapsed since the worker reached age 21, ending in the quarter in which the worker became disabled. However, a minimum of 6 quarters is required.

BENEFIT COMPUTATION

DI benefits are computed in the same manner as old age and survivors benefits except that the number of years of earnings which is excluded when determining the benefit amount is less than 5 for workers under age 47. (The number of drop-out years allowed increases with the age of the insured worker at disablement.) The amount of the monthly benefit is based on the insured worker's primary insurance amount (PIA).

The following table lists major disability benefits with the percentage of the insured worker's PIA.

TABLE 2.—TYPE OF MONTHLY BENEFIT

	Percent of PIA
Disabled worker (any age)	100
Dependents of disabled worker: [1] Wife or husband (age 62), mother, father, children and grandchildren	50
Survivors: [1] Disabled (age 50–59), widows or widowers	71.5

[1] Subject to maximum family benefit limitation.

Substantial gainful activity

The Secretary of HHS[1] has specific regulatory authority to prescribe the criteria for determining when earnings derived from employment demonstrate an individual's ability to engage in substantial gainful activity (SGA).

The Secretary has published regulations specifying the monetary amounts which indicate substantial gainful activity. Effective January 1, 1990, the SGA earnings level was raised to $500 a month (net of impairment-related work expenses). It will remain at this level for 1991.

---

[1] Throughout the remainder of this section when Secretary is used, it is the Secretary of Health and Human Services.

TABLE 3.—MONTHLY SGA AMOUNTS

Year	SGA
July 1968–73	140
1974–75	200
1976	230
1977	240
1978	260
1979	280
1980–89	300
1990	500

Work Incentives

The law provides a 45-month period for disabled beneficiaries to test their ability to work without losing their entitlement for benefits. The period consists of (1) a 9-month "trial work period" (TWP) during which benefits are not suspended because of work, and (2) a 36-month "extended period of eligibility," during the last 33 of which benefits are suspended for any month in which the individual is engaged in substantial gainful activity (SGA). However, during the extended period of eligibility, entitlement to benefits is not terminated. Medicare benefits may be continued for 48 months after the TWP begins. When the person's Medicare benefits end on account of his work activity, and he continues to be disabled, the person may purchase Medicare protection.

If an individual medically recovers to the extent that he no longer meets the definition of disability, benefits are terminated regardless of the trial work period or extended period of eligibility provisions. Effective January 1, 1992, due to Public Law 101–508, the TWP will only be completed if a person completes 9 service months within a 60-month period. In addition, effective January 1, 1992, beneficiaries will get a new TWP for each period of eligibility. Only one trial work period is permitted for each period of disability. The Secretary of HHS has provided by regulation that earnings of more than $200 a month will constitute a month of "trial work."

DI maximum family benefit

The maximum monthly amount of DI family benefits which is payable on a disabled worker's earnings record for workers who first become entitled after June 1980, is the smaller of 85 percent of the worker's average indexed monthly earnings or 150 percent of the worker's primary insurance amount. However, in no case can the benefit be reduced below 100 percent of the worker's primary insurance amount.

Offset for other public disability benefits

When a disabled worker under age 65 qualifies on the basis of total or partial disability (whether or not permanent) for benefits which are provided by Federal, State and local governments and worker's compensation, the Social Security benefits payable to him and his family are reduced by the amount, if any, that the total monthly benefits payable under the two or more programs exceed 80 percent of his average current earnings before he became disabled. Needs-tested benefits, Veterans' Administration disability benefits, and benefits based on public employment covered by Social Security are not subject to the provision. A worker's average current earnings for this purpose are the larger of (a) the average monthly earnings used for computing his Social Security benefits, or (b) his average monthly earnings in employment or self-employment covered by Social Security during the 5 consecutive years of highest covered earnings after 1950, or (c) the average monthly earnings during the calendar year of highest earnings during a period consisting of the year in which disability began and the preceding 5 years without regard to the limitations which specify a maximum amount of earnings creditable for Social Security benefits. The combined payments after the reduction are never less than the total amount of the DI benefits payable before the reduction. In addition, the Social Security benefit after the reduction is increased by the full amount of the cost-of-living increase as applied to the unreduced benefit. Every 3 years the original amount of benefits subject to reduction is redetermined to reflect changes in average wage levels. If increases in the average national wages would result in a higher benefit than that payable based on the original computation, the benefit is increased effective January of the redetermination year.

The offset begins in the month during which concurrent entitlement begins under a Federal or State law.

The offset of the Social Security disability benefit will not be made if the State worker's compensation law provides for an offset against Social Security disability benefits. However, this waiver of the offset only applies where the State program began offsetting on or before February 18, 1981.

DETERMINATION OF DISABILITY

State agency determinations of disability

Disability determinations are made by State agencies which agree to make such determinations and substantially comply with the regulations of the Secretary. The Secretary is required to issue regulations specifying, in such detail as he or she deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function "in order to assure effective and uniform administration of the disability insurance program throughout the United States." Certain operational areas are cited as "examples" of what the regulations may specify. These include such items as the nature of the administrative structure, the physical location of and relationship among agency staff units, performance criteria and fiscal control procedures.

The law also provides that if the Secretary finds that a State agency is substantially failing to make disability determinations consistent with his regulations, the Secretary shall, not earlier than 180 days following his findings, terminate State administration and make the determinations himself. The law also allows for termination by the State. The State would be required to continue to make disability determinations for not less than 180 days after notifying the Secretary of its intent to terminate. Thereafter, the Secretary would be required to make the determinations.

Determining disability: Application of law and regulations

The adjudication of claims is accomplished on a sequential basis. Whether the individual is currently employed and the amount of earnings are the first factors considered. If the individual is earning the amount that indicates ability to engage in "substantial gainful activity" (SGA, now $500 a month), he is determined not disabled. If he is making less than this amount or not working at all, the severity and duration of the impairment are explored. If the severity is determined to be "not severe" (i.e., the individual's impairment does not significantly limit his capacity to perform work), the individual is denied right at that point. It is important to note that the "severity" step had become very controversial in recent years, with several Federal circuit courts ruling that SSA's procedures violate the intent of the law that every claimant receive an individual determination based on medical and vocational factors. However, in a recent decision, the Supreme Court, while raising a number of concerns about SSA's procedures, upheld the Agency's application of the "severity" test at this stage of the sequential process.[2] If the impairment is "severe," a determination is made as to whether the impairment "meets" or "equals" the medical listings published in regulations by SSA [3] and whether it will last for 12 months. If it neither "meets" nor "equals" the listing (which will result in an allowance) but meets the 12-month duration rule, a determination is then made of whether the claimant is able to carry out his former occupation. If he can, he is denied benefits; if he cannot, the nonmedical factors come into play.

At this stage, because of a judicial opinion and subsequent administrative and legislative ratification, the burden of proof switches to the Government to show that the individual can, considering his impairment, age, education, and work experience, engage in some other kind of substantial gainful activity which exists in the national economy. Such work, however, does not have to exist in the immediate area in which he lives and a specific job vacancy does not have to be available to him. Work in the national economy is defined in the law as work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

In the face of a growing number of nonmedical allowances and a declining number of cases where the medical listings were met, SSA in 1976 developed a vocational "grid" designed to reduce the subjectivity and lack of uniformity in applying the vocational factor. The grid regulations were designed to embody in a formula certain worker characteristics such as age, education, and past work experience, in relation to the individual's residual functional capacity (RFC) to perform work-related physical and mental activities. If the claimant has a particular level of residual work capability—characterized by the terms Sedentary, Light, Medium, Heavy and Very Heavy—an automatic finding of "disabled" or "not disabled" is required when applied to various combinations of age, education, and work experience.

---

[2] *Bowen* v. *Yuckert*, No. 85-1409, June 8, 1987.

[3] The Listing of Impairments contains over 100 examples of medical conditions that would ordinarily prevent an individual from engaging in any gainful activity. Each listing describes a degree of severity such that an individual who is not working and has such an impairment is considered unable to work by reason of the medical impairment. The listing describes specific medically acceptable clinical and laboratory findings and signs which establish the severity of the impairments. An impairment or combination of impairments is said to "equal the listings" if the medical findings for the impairment are at least equivalent in severity and duration to the listed findings of a listed impairment.

The regulations were finally promulgated in February 1979, after some lengthy administrative hearings and consideration. During the period 1975-1983, there was a decline at the State agency level in the number of nonmedical allowances and an increase in the percentage of allowed cases which "met" or "equaled" the medical listings. Those percentages are presented in table 4 and show this trend has reversed itself since 1984. Moreover, there was an equally dramatic increase during the period from 1975 through 1983 in the number of denials on the basis of "impairment not severe" which under the sequential method of determining disability would exclude the consideration of the nonmedical factors. This trend also seems to have slowed since 1984. Table 5 gives a percentage distribution of the basis for denials at the initial determination of disability at the State agency level for fiscal years 1975 to 1990.

TABLE 4.—BASIS FOR TITLE II ALLOWANCES—NATIONAL FIGURES: INITIAL WORKER DETERMINATION, FISCAL YEARS 1975-90

[In percent]

Fiscal year	Meets listing	Equals listing	Medical and vocational considerations
1975	29.4	43.9	26.7
1976	29.0	45.1	25.9
1977	34.2	41.9	23.9
1978	45.6	31.9	22.5
1979	55.1	22.7	22.1
1980	57.9	16.2	25.9
1981	63.9	12.3	23.8
1982	72.7	8.6	18.7
1983	74.0	8.3	17.7
1984	66.7	8.7	24.6
1985	62.7	9.2	28.1
1986	68.2	8.7	23.1
1987	66.0	10.2	23.8
1988	64.3	11.0	24.7
1989	62.1	11.3	26.6
1990	59.0	11.8	29.2

Source: Office of Disability, Social Security Administration.

TABLE 5.—BASIS FOR TITLE II DISALLOWANCES AND DENIALS—NATIONAL FIGURES: INITIAL WORK DETERMINATION, FISCAL YEARS 1975–90

[In percent]

	Duration	Slight impairment	Able to perform usual work	Able to perform other work	Engaging in SGA	Failure to cooperate	Failure to appear	Other
1975	19.6	8.4	44.3	18.2	1.0	5.1	1.8	1.6
1976	19.9	10.8	41.9	20.1	.4	4.8	1.8	.3
1977	21.2	24.8	30.0	15.7	.5	4.9	1.8	1.1
1978	21.1	31.8	25.0	14.6	.5	4.1	1.9	1.0
1979	20.0	41.6	21.5	12.5	.4	.9	2.3	.8
1980	20.6	39.0	23.7	12.7		1.9	1.3	.7
1981	17.5	43.2	18.7	11.3	2.0		2.6	4.8
1982	16.4	38.9	22.6	14.1	1.1		2.8	3.6
1983	16.9	39.4	22.0	14.3	1.0		3.0	3.4
1984	14.8	34.3	23.8	16.7	1.0	2.0	2.3	5.1
1985	15.4	23.3	35.4	20.3	1.1		2.2	2.3
1986	14.2	20.1	38.4	20.5	.2		2.5	4.1
1987	15.8	18.3	38.2	21.7	1.0		2.5	2.5
1988	15.9	20.3	34.2	22.8	.9		2.5	3.4
1989	15.7	20.7	32.7	24.9	.4		2.5	3.2
1990	15.1	21.4	31.0	26.3	.4		2.6	3.3

Source: Office of Disability, Social Security Administration.

A widow or widower may qualify for benefits on the deceased spouse's work record at age 50 and over. Effective January 1991, the requirements for a widow or widower to qualify for disability benefits are the same as those for a worker.

Federal review of State determination

The Secretary may, on his own motion, review any determination by a State agency.

The law requires that the Secretary review 50 percent of the disability allowances and a sufficient number of other determinations to ensure a high degree of accuracy.

Periodic review of individuals receiving disability benefits

The 1980 Disability Amendments required that the Social Security Administration reexamine every individual on the rolls who is determined to be nonpermanently disabled for benefit eligibility at least once every 3 years. Where there is a finding of permanency, the Secretary may reexamine at such times as is determined to be appropriate. These reviews are in addition to the administrative eligibility review procedures existing prior to the 1980 amendments. Legislation enacted in late 1982 provided authority for the Secretary to slow down the rate of continuing eligibility reviews mandated by the 1980 amendments.

Medical improvement standard

The 1984 Disability Benefits Reform Act amended the law to require that in continuing eligibility review cases, benefits may be terminated only if the Secretary finds that there has been medical improvement in the person's condition and that this improvement has enabled the person to engage in substantial gainful activity. There are several statutory exceptions to this standard, which are described in greater detail in the "Recent Legislation" section of this chapter.

Medical evidence

An individual is not considered under a disability unless he furnishes such medical and other evidence as the Secretary may require.

Under the law, the Secretary will generally reimburse physicians or hospitals for supplying medical evidence in support of claims for DI benefits. The Secretary also pays for medical examinations which are needed to adjudicate the claim.

Attorneys' fees and representation

Attorneys and other individuals who represent disability claimants on appeal and who wish to charge a fee for their services must have the fee approved by the Social Security Administration (SSA). Under the law in effect through June 30, 1991, representatives must submit a fee petition detailing the number of hours spent on the claim and requesting a specific fee. If the fee requested is less than $4,000, the Administrative Law Judge (ALJ) who heard the case has authority to approve or modify it. If the requested fee exceeds $4,000, it is reviewed and approved or modified by the regional Chief ALJ.

The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) generally replaced the fee petition process (effective July 1, 1991) with a streamlined process in which SSA will approve any fee agreement jointly submitted by the claimant and the representative if the claimant is successful in his or her appeal for benefits and if the agreed-upon fee does not exceed 25 percent of past-due benefits, but not to exceed $4,000.

As under previous law, the Secretary would continue to withhold 25 percent of the past-due benefits of a claimant represented by an attorney and pay the attorney the approved fee directly.

A court which renders a decision favorable to a claimant for social security benefits is permitted to set a reasonable fee for the attorney who represented the claimant before the court. The fee cannot exceed 25 percent of the past-due benefits which result from the court's decision. The Secretary may certify for payment to the attorney, out of the total of the past-due benefits, the amount of the fee set by the court.

VOCATIONAL REHABILITATION

The Social Security Act requires that persons applying for a determination of disability be promptly referred to State vocational rehabilitation agencies for necessary rehabilitation services. The act provides for withholding of benefits for refusal, without good cause, to accept rehabilitation services available under a State plan approved under the Vocational Rehabilitation Act in such amounts as the Secretary shall determine.

Public Law 97-35 eliminated reimbursement from the trust funds to the State vocational rehabilitation agencies for rehabilitation services except in cases where the services have resulted in the beneficiary's performance of substantial gainful activity (SGA) for a continuous period of at least 9 months. Such a 9-month period could begin while the individual is under a vocational rehabilitation program and may also coincide with the trial work period or the individual's waiting period for benefits. The services must be performed under a State plan for vocational rehabilitation services under title I of the Rehabilitation Act. In the case of any State which is unwilling to participate or which does not have a plan which meets the requirements of the Vocational Rehabilitation Act, the Commissioner of Social Security may provide such services by agreement or contract with other public or private agencies, organizations, institutions or individuals. The determination that the vocational rehabilitation services contributed to the successful return of the individual to SGA, and the determination of the amount of costs to be reimbursed, are made by the Commissioner of Social Security in accordance with criteria formulated by him. Payments under this provision can be made in advance or by way of reimbursement, with necessary adjustments for overpayments or underpayments.

Disability Claims and Appeals Structure

The Social Security appeals and case review process is a complex multilayered structure which is inextricably linked with the disability determination process. Since about 97 percent of the hearing requests involve disability claims (both Social Security and supplemental security income), the process described will be for that type of claim. The application for disability benefits is made at the Federal Social Security district office where the claimant is interviewed and the sources of medical evidence are recorded. After determining whether the applicant meets the insured status requirements, the case is then sent to the State agency which, operating as an agent of the Social Security Administration, makes the initial determination of disability. If a claimant or terminated beneficiary is dissatisfied with an initial denial or termination of disability benefits by the State agency, he can request a reconsideration within 60 days of notice of denial. The reconsideration is also carried out by the State agency, but by personnel other than those who made the initial determination. If upon reconsideration the claimant is again denied benefits, he will be given a hearing before an administrative law judge (ALJ), providing he files a request within 60 days of notice of denial. If the claim is denied by the ALJ, the claimant has 60 days to request review by the Appeals Council. The Appeals Council may also, on its own motion, review a decision within 90 days of the ALJ's decision. The 1980 Disability Amendments required the Secretary to review a percentage of ALJ hearing decisions, and this review is being conducted by the Appeals Council.

The Appeals Council may review, affirm, modify or reverse the decision of the ALJ, or it may remand it to the ALJ for further development. The claimant is notified in writing of the final action of the Appeals Council, and is informed of his right to obtain further review by commencing a civil action within 60 days in a United States district court.

Under current law, as amended by the 1984 Disability Benefits Reform Act, DI beneficiaries whose benefits have been terminated for medical reasons, e.g., recovery or improvement in the medical condition which was the basis for the disability, can elect to continue to receive benefits through the appeals process. These benefits are subject to recovery as an overpayment, however, in the event that the initial termination decision is upheld by an ALJ.

Table 6 shows the number of cases allowed and appealed at various levels of appeal for application decisions and Continuing Disability Reviews (CDRs) processed by State agencies. Of the 1,589,311 initial application decisions by State agencies in fiscal year 1990, some 39 percent were allowed and of the 182,679 CDRs 89 percent were continued in benefit status.

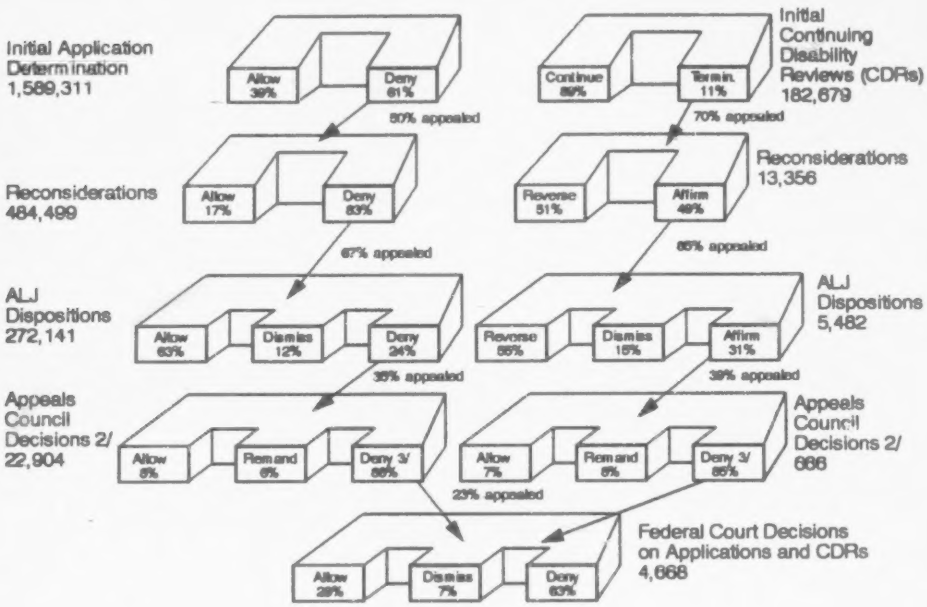
Of the initial application decisions some 61 percent were denied. Nearly half (50 percent) of these appealed their denials to the reconsideration level. After all levels of appeal had been exhausted, about 27 percent of those denied benefits initially had benefits granted to them through the appeals process. When appeals allowances are considered, some 45 percent of the initial application decisions were finally denied.

Of the initial CDRs, some 11 percent were terminated. Seventy percent of these appealed their terminations. After all levels of appeal had been exhausted, about 52 percent of those terminated beneficiaries had benefits reinstated through the appeals process. When appeals continuances are considered, about 5 percent of the initial CDRs were finally terminated.

Table 7 presents information for fiscal years 1979 through 1990 of the number of cases which are reviewed and reversed at the ALJ level. Approximately 57.1 percent of initial denials were reversed in 1987 (that is, judged favorable to the individual), 59.2 percent were reversed in 1988, 62.3 percent were reversed in 1989, and 66.4 percent were reversed in 1990.

TABLE 6. DISABILITY DETERMINATIONS AND APPEALS, FISCAL YEAR 1990

TITLE II, TITLE XVI AND CONCURRENT TITLE II AND XVI DECISIONS FOR DISABILITY CLAIMS BY WORKERS, WIDOWS, WIDOWERS AND DISABLED ADULT CHILDREN[1]


Initial Application Determination 1,589,311
Allow 39%
Deny 61%
50% appealed
Initial Continuing Disability Reviews (CDRs) 182,679
Continue 89%
Termin. 11%
70% appealed
Reconsiderations 484,499
Allow 17%
Deny 83%
67% appealed
Reconsiderations 13,356
Reverse 51%
Affirm 49%
86% appealed
ALJ Dispositions 272,141
Allow 63%
Dismiss 12%
Deny 24%
35% appealed
ALJ Dispositions 5,482
Reverse 55%
Dismiss 15%
Affirm 31%
39% appealed
Appeals Council Decisions 2/ 22,904
Allow 8%
Remand 6%
Deny 3/ 86%
Appeals Council Decisions 2/ 666
Allow 7%
Remand 8%
Deny 3/ 85%
23% appealed
Federal Court Decisions on Applications and CDRs 4,668
Allow 29%
Dismiss 7%
Deny 63%

% of Total Allowances	
Total	100.0
Initial Decisions 4/	74.6
Initial Applications	59.3
CDR	15.3
Reconsiderations	8.4
ALJs	16.7
Appeals Council	.2
Federal Court	.1

---

[1] The data relate to workloads processed at various levels in fiscal year 1990, but include some cases where the initial level decision was made in a prior period. The data include determinations on initial applications as well as continuing disability reviews (both periodic reviews and medical diary cases).

[2] Includes ALJ decisions not appealed further by the claimant but reviewed by the Appeals Council on its "own motion" authority.

[3] Includes dismissals, denials of requests for review, and affirmations of denial.

[4] Initial determinations plus CDRs.

Source: Office of Disability, Social Security Administration.

TABLE 7.—ADMINISTRATIVE LAW JUDGE FAVORABLE RATES—DISABILITY INSURANCE [1] INITIAL DENIALS AND TERMINATIONS,[2] FISCAL YEARS 1979–90

Fiscal year	Dismissed	Unfavorable	Favorable	Total	Percent favorable
Initial denials:					
1979	6,332	31,485	48,934	86,751	56.4
1980	7,093	31,703	56,733	95,529	59.4
1981	15,141	59,930	98,129	173,200	56.7
1982	15,403	67,481	91,865	174,749	52.6
1983	14,334	65,626	79,427	159,387	49.8
1984	15,075	63,381	88,301	166,757	53.0
1985	14,806	61,161	92,118	168,085	54.8
1986	28,792	44,223	78,737	151,752	51.9
1987	15,271	58,412	98,180	171,863	57.1
1988	18,213	58,788	111,748	188,749	59.2
1989	19,695	54,284	122,070	196,049	62.3
1990	19,297	45,264	127,707	192,268	66.4
Terminations:					
1979	1,401	4,078	8,052	13,531	59.5
1980	1,431	4,197	9,909	15,537	63.8
1981	2,623	6,945	16,685	26,253	63.6
1982	4,670	17,502	37,306	59,478	62.7
1983	9,247	37,284	73,821	120,352	61.3
1984	25,681	22,590	56,327	104,598	53.9
1985	4,176	2,415	3,126	9,717	32.2
1986	1,095	2,129	2,014	5,238	38.4
1987	812	1,954	2,014	4,780	42.1
1988	1,031	2,807	3,426	7,264	47.2
1989	1,220	3,482	4,882	9,584	50.9
1990	1,166	2,940	4,695	8,801	53.3

[1] Includes title II and concurrent title II/title XVI disability cases and concurrent title II/title XVI aged cases.
[2] Includes all termination cases regardless of the basis for termination.

Source: Office of Hearings and Appeals, Social Security Administration.

Table 8 presents information on the number of continuing disability reviews—title II cases—that were conducted in fiscal years 1977–90. From fiscal year 1977 to 1981 the number of cases reviewed ranged from 2.4 percent to 4.9 percent of the total number of disabled persons on the Social Security rolls. With the administration's implementation of the provision of the 1980 disability amendments calling for more periodic reviews of eligibility, in 1981–83 the percent of cases reviewed rose sharply, reaching 13.5 percent of the caseload in 1983, the highest rate of review during the 11-year period. While the number of reviewed cases rose, the percent of cases terminated at the initial stage of review stayed fairly stable. The initial-stage termination rate during the 1977–83 period ranged from about 39 to 48 percent, and for the most part hovered in the range of 45 to 48 percent. Thus, the number of terminations rose sharply beginning in 1981 as the case-review workload mounted, peaking at 182,000 in 1983. This was more than four times the number of annual initial-stage terminations that occurred during the 1977–80 period. A sharp decline in the number of reviews occurred in 1984 and 1985, reflecting the Secretary's moratorium on reviews pending enactment of the 1984 disability legislation and the subsequent delay in implementing the legislation. Only a little more than 3,000 cases were reviewed in 1985 and less than 2,800 initial-stage terminations were rendered.

With the reimplementation of the review process in the spring of 1986, the number of cases subjected to reexamination began rising again. The percent of the disability rolls reviewed in 1988 reached 8.3 percent, a higher level than that reached in 1981 and considerably higher than the levels of the 1977–80 period. In contrast to those earlier years, however, the rate of termination under the new review procedures has thus far been much lower. Approximately 5 to 12 percent of the cases reviewed during 1986–90 were terminated, far lower than the 39–47 percent termination rate of the 1977–80 period. Consequently, while the number of cases being reviewed now appears to be relatively high, the number of initial-stage terminations is much lower than in the 1977–80 period.

TABLE 8.—CONTINUING DISABILITY REVIEWS (CDR) INITIAL DECISIONS: TITLE II DISABLED WORKERS, DISABLED WIDOWS AND WIDOWERS, AND DISABLED CHILDREN CESSATIONS AND CONTINUATIONS, FISCAL YEARS 1977–90

	Cessations		Continuations		Total cases		
	Number	Percent	Number	Percent	Cessations and continuations	Total disabled persons	Percent reviewed
1977	41,475	38.7	65,745	61.3	107,220	[1] 3,322,230	3.2
1978	38,847	46.4	44,804	53.6	83,651	3,447,767	2.4
1979	45,216	48.1	48,868	51.9	94,084	3,457,837	2.7
1980	44,273	46.8	50,227	53.2	94,550	3,454,010	2.7
1981	80,956	47.9	87,966	52.1	168,922	3,413,602	4.9
1982	179,857	44.8	221,325	55.2	401,182	3,263,354	12.3
1983	182,074	41.7	254,424	58.3	436,498	3,226,888	13.5
1984 [2]	31,927	24.6	97,752	75.4	129,679	3,249,367	4.0
1985 [2]	475	14.6	2,785	85.4	3,260	3,332,870	.1
1986	2,554	5.6	42,805	94.4	45,359	3,261,768	1.4
1987	20,343	12.4	143,712	87.6	164,055	3,433,524	4.8
1988	33,565	11.5	257,377	88.5	290,942	3,492,762	8.3
1989	24,102	9.2	237,722	90.8	261,824	3,559,840	7.4
1990 [3]	15,154	10.5	129,026	89.5	144,180	3,078,509	3.9

[1] In current pay at end of fiscal year.

[2] The decline in the number of reviews in 1984 and 1985 was due to the national moratorium on reviews pending enactment and implementation of the new legislation with revised criteria for CDR's (enacted in fiscal year 1984, regulations promulgated late fiscal year 1985).

[3] The decline in CDR processing in 1990 was due to the unanticipated processing of approximately 40,000 class action court cases.

Source: Office of Disability, Social Security Administration.

RECENT EXPERIENCE IN THE DISABILITY PROGRAM

After peaking at an all-time high in 1978, the number of beneficiaries on the DI rolls declined significantly from 4.868 million in 1978 to 3.813 million in December 1983. This was a decline of 21.7 percent. The number of awards declined from 592,049 in 1975 to approximately 298,531 in 1982. Awards increased in 1985 (377,371) and 1986 (416,865) and declined in 1987 (415,848) and 1988 (409,490). The incidence of disability (number of awards per 1,000 insured workers) fell from an all-time high of 7.1 in 1975 to 2.9 in 1982, the lowest incidence rate in the history of the program, and now stands at 4.0 for 1990. (See table 9.)

Table 10 shows the number of DI beneficiaries for selected years.

TABLE 9.—DISABLED WORKERS' APPLICATIONS, AWARDS AND RATIO OF AWARDS TO APPLICATIONS AND AWARDS PER 1,000 INSURED WORKERS FOR 1960, 1965, 1970 TO 1990

	Number of applications (in thousands)	Total awards	Total awards divided by total applications (percent)	Awards per 1,000 insured workers
1960	418.6	207,805	50	4.5
1965	532.9	253,499	48	4.7
1970	868.2	350,384	40	4.8
1971	924.4	415,897	45	5.6
1972	947.8	455,438	48	6.0
1973	1,066.9	491,616	46	6.3
1974	1,330.2	535,977	40	6.7
1975	1,285.3	592,049	46	7.1
1976	1,232.2	551,460	45	6.5
1977	1,235.2	568,874	46	6.5
1978	1,184.7	464,415	39	5.2
1979	1,187.8	416,713	35	4.4
1980	1,262.3	396,559	31	4.0
1981	1,161.3	345,254	30	3.4
1982	1,020.0	298,531	29	2.9
1983	1,017.7	311,491	31	3.0
1984	1,035.7	357,141	34	3.4
1985	1,066.2	377,371	35	3.5
1986	1,118.4	416,865	37	3.8
1987	1,108.9	415,848	37	3.7
1988	1,017.9	409,490	40	3.6
1989	984.9	425,582	43	3.7
1990	1,067.7	467,977	44	4.0

Source: Office of the Actuary, Social Security Administration.

TABLE 10.—NUMBER OF DISABILITY INSURANCE BENEFICIARIES FOR SELECTED YEARS: 1960–90

[Current payment status, December]

	Disabled workers	Spouses	Children	Total
Year:				
1960	455,371	76,599	155,481	687,451
1965	988,074	193,362	557,615	1,739,051
1970	1,492,948	283,447	888,600	2,664,995
1975	2,488,774	452,922	1,410,504	4,352,200
1980	2,861,253	462,204	1,358,715	4,682,172
1981	2,776,519	428,212	1,251,543	4,456,274
1982	2,603,713	365,883	1,003,869	3,973,465
1983	2,568,966	308,060	935,904	3,812,930
1984	2,596,535	303,984	921,285	3,821,804
1985	2,656,500	305,528	945,141	3,907,169
1986	2,727,386	300,592	965,301	3,993,279
1987	2,785,885	290,895	967,944	4,044,724
1988	2,830,284	280,821	963,195	4,074,300
1989	2,895,364	271,488	961,975	4,128,827
1990	3,011,294	265,890	988,797	4,265,981

Source: Office of Research and Statistics, Social Security Administration.

CHARACTERISTICS OF DI BENEFICIARIES

Tables 11 and 12 present data on the demographic, social, and medical characteristics of the disabled population over time. For instance, table 11 shows the increase in the receipt of benefits by women, which reflects larger societal trends in female workforce participation. Table 11 indicates the higher levels of educational attainment that characterize the present disabled population in comparison to that of 1970.

TABLE 11.—PERCENT DISTRIBUTION BY AGE, SEX AND EDUCATION OF TITLE II DISABLED WORKER BENEFICIARIES ALLOWED BENEFITS IN SELECTED CALENDAR YEARS 1970–90, COMPARED WITH ADULT U.S. POPULATION IN 1980

Characteristics	Year allowed benefits									Adult U.S. population [1]
	1970	1975	1979	1982	1985	1987	1988	1989	1990	
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Age:										
Under 35	9.0	11.0	13.6	14.4	16.8	17.1	15.2	16.2	15.7	49
35 to 44	11.0	10.0	11.5	12.3	15.0	16.0	16.5	17.9	18.7	19
45 to 54	26.0	26.0	27.2	26.5	25.7	22.9	23.3	24.7	24.7	16
55 to 59	24.0	23.0	27.0	27.2	23.9	20.8	20.6	20.4	19.9	8
60 and over	30.0	30.0	20.6	19.6	18.7	23.2	24.4	20.9	21.0	8
Median age (years)	56.0	55.6	53.4	53.1	51.7	53.0	53.3	52.1	51.9	35.4
Sex:										
Male	74	68	69	70	67	66	66	64	64	49
Female	26	32	31	30	33	34	34	36	36	51
Education (years of school completed):										
No schooling	2	1	1	1	[2] 2	[3] 1	[4] 1	[5] 1	[6] 1	2
Elementary school (1 to 8)	44	37	29	26	23	18	18	17	16	17
High school	46	52	55	56	59	57	59	60	62	51
9 to 11	23	24	23	22	22	19	20	19	19	14
12	23	28	32	34	37	38	39	41	43	37
Some college	9	10	12	14	14	16	15	17	17	32
Unknown	0	0	3	3	2	8	7	5	5	2

[1] Derived from 1980 Census. Figures for age based on population aged 18–64. Figures for education based on persons aged 25 and over. [2] Special schools for handicapped (1.2 percent) and no schooling (0.7 percent). [3] Special schools for handicapped (0.3 percent) and no schooling (0.5 percent). [4] Special schools for handicapped (0.3 percent) and no schooling (0.3 percent). [5] Special schools for handicapped (0.3 percent) and no schooling (0.2 percent). [6] Special schools for handicapped (0.3) and no schooling (0.3 percent).

NA—Not available. Source: Office of Disability, Social Security Administration.

TABLE 12.—PERCENT DISTRIBUTION BY DISABLING CONDITION OF TITLE II DISABLED WORKER BENEFICIARIES ALLOWED BENEFITS IN SELECTED CALENDAR YEARS 1970–90

Disabling condition and mobility	Year allowed benefits								
	1970	1975	1979	1982	1985	1987	1988	1989	1990
Total percent	100	100	100	100	100	100	100	100	[1] 100
Disabling condition:									
Infective and parasitic diseases	3	1	1	1	1	1	0	1	[2] 6
Neoplasms	10	10	14	17	15	12	16	18	17
Allergic, endocrine system, metabolic and nutritional diseases	4	3	3	4	5	5	3	3	3
Mental, psychoneurotic and personality disorders	11	11	11	11	18	23	22	22	23
Diseases of the nervous system and sense organs	6	7	8	9	8	8	8	9	9
Circulatory system	31	32	28	25	19	17	18	17	16
Respiratory system	7	7	6	7	5	5	5	5	5
Digestive system	3	3	2	2	2	1	2	2	2
Skeletal musculo	15	17	17	16	13	14	14	11	12
Accidents, poisonings and violence	8	6	6	6	4	5	5	4	4
Other/unknown	2	3	3	2	11	9	7	9	5

[1] Due to rounding, may not add to 100 percent.

[2] AIDS/HIV cases are now properly coded as infectious diseases.

Source: Office of Disability, Social Security Administration.

GAO STUDY OF TERMINATED BENEFICIARIES: 1981–84

In response to a request from the House Ways and Means Subcommittee on Social Security, the General Accounting Office (GAO) issued a report in November 1989, which compared the health, employment, and financial status of Disability Insurance (DI) beneficiaries with that of denied applicants and beneficiaries removed from the rolls during 1981–84. Based on written and oral interviews with a random sample of these individuals, the GAO found that:

1. *Most DI beneficiaries removed from the rolls between 1981 and 1984 have been reinstated. However, of those who were not, nearly half are not working.*—As of 1987, 63 percent of the beneficiaries who were determined ineligible for benefits during SSA's 1981–84 review had been reinstated to the disability benefit rolls. Another 4 percent had begun to receive Social Security retirement benefits, and 7 percent had died. Al-

together, only about 26 percent of those found ineligible remained terminated; 58 percent of these terminated individuals (or 15 percent of those earlier found ineligible) had returned to work.

2. Denied applicants continue to have employment problems.—About 58 percent of the applicants who were denied benefits in 1984 and were not receiving benefits as of 1987 reported they were not working. Over two-thirds of these nonworking denied applicants had been out of work for at least 3 years, and 54 percent said they did not expect to ever work again. Of the denied applicants who were working at the time of GAO's survey, 71 percent said that because of their health, they were limited in the kind or amount of work that they could do. Over 40 percent were earning less in 1986 than they were before applying for disability.

3. Both DI beneficiaries and denied applicants who are not working report poor health.—GAO assessed the survey respondents' health status on the basis of their self-perceptions and reported abilities to perform the activities of daily living and personal care. Although the health status reported by denied applicants was slightly better than that of the allowed population, both generally reported poor health. In addition, self-reported health status differed significantly between the denied who worked and those who did not. After separating the denied into working and nonworking groups, the self-reported health status of the nonworking denied group closely resembled that reported by the allowed population; and both were significantly worse than that of the working denied. For example:

—80 percent of the nonworking denied group and 78 percent of the allowed population perceived their health as fair to poor, with about 44 percent of both stating they were in poor health; in contrast, only 13 percent of the working denied said they were in poor health;

—40 percent of the nonworking denied group and 51 percent of the allowed population said they had to depend on others for at least one personal care activity, such as dressing, eating, or getting in and out of bed; only 12 percent of the working denied needed any help; and

—71 percent of the nonworking denied group and 76 percent of the allowed population could be classified as having severe functional limitations; in comparison, only 41 percent of the working denied could be so classified.

4. DI beneficiaries' impairments differed from those of denied applicants.—The denied applicants (both working and nonworking) reported back problems as the impairment that limited them the most; the allowed population most often reported mental and heart problems.

5. Both the allowed and denied populations reported serious financial problems.—The median family income reported by the nonworking denied was about $6,500 in 1986. Total family income was below Census's poverty level for 61 percent of this group, and 35 percent depended on government programs other than Social Security (mainly public assistance) for half or more of their total family income.

Despite receiving DI benefits, 33 percent of the allowed population said they lacked enough income to get along; 43 percent reported income that is below the poverty level. At the time of GAO's survey in 1987, a significant proportion of the denied groups were without medical insurance coverage. Twenty-nine percent of the working denied and 25 percent of the nonworking denied reported no medical insurance coverage. Most of those without insurance said they had been without it since 1984 or earlier.

LEGISLATIVE CHANGES, 1984–90

98TH CONGRESS: THE DISABILITY BENEFITS REFORM ACT OF 1984

Public Law 98–460, the Disability Benefits Reform Act of 1984, made several substantial changes in the standards for review of disability beneficiaries, and in other provisions of the program as well. The following is a summary of the law.

1. Medical improvement standard

Public Law 98–460 established a medical improvement standard under which the Secretary may terminate disability benefits on the basis that the person is no longer disabled only if:

(1) There is substantial evidence demonstrating that (a) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the person's ability to work), (b) the individual is now able to engage in substantial gainful activity (SGA); or

(2) There is substantial evidence consisting of new medical evidence and a new assessment of RFC which demonstrates that although there is no medical improvement, (a) the person has benefited from advances in medical or vocational therapy or technology related to ability to work, and (b) that he or she is now able to perform SGA; or

(3) There is substantial evidence that although there is no medical improvement (a) the person has benefited from vocational therapy and (b) the beneficiary can now perform SGA; or

(4) There is substantial evidence that, based on new or improved diagnostic techniques or evaluations, the person's impairment or combination of impairments is not as disabling as it was considered to be at the time of the prior determination, and that therefore the individual is able to perform SGA; or

(5) There is substantial evidence either in the file at the original determination or newly obtained showing that the prior determination was in error; or

(6) There is substantial evidence that the original decision was fraudulently obtained; or

(7) If the individual is engaging in SGA (except where he or she is eligible under Section 1619), fails without good cause to

cooperate in the review or follow prescribed treatment or cannot be located.

In making the determination, the Secretary was required to consider the evidence in the file as well as any additional information concerning the claimant's current or prior condition secured by the Secretary or provided by the claimant.

Determinations under this provision had to be made on the basis of the weight of the evidence, and on a neutral basis with regard to the individual's condition, without any inference as to the presence or absence of disability based on the previous finding of disability.

Effective date: Applied only with respect to the following categories:

(1) Determinations by the Secretary made after the date of enactment;

(2) Cases pending at any level of the administrative process on the date of enactment;

(3) Cases of individual litigants pending in Federal court on the date the conference report was filed;

(4) Cases of named plaintiffs in class action suits pending on that date;

(5) Cases of unnamed plaintiffs in class action suits certified prior to that date; and

(6) Cases where a request for judicial review was made on a decision of the Secretary made during the 60 days preceding enactment.

Cases in categories (3), (4), (5), and (6) had to be remanded to the Secretary for review under this standard. Individuals in (5) were to be sent a notice via certified mail informing them that they had 120 days after the date of receipt of the notice to request a review under the medical improvement standard.

No class action could be certified after the date the conference report was filed which raised the issue of medical improvement with respect to an individual whose benefits were terminated prior to that date.

Persons whose cases were remanded to the Secretary were to receive benefits pending the Secretary's decision and appeal of that decision if they so elected. If found eligible, any person whose case was remanded under this provision was to receive benefits retroactive to the date they were last found ineligible.

2. Evaluation of pain

The Secretary of HHS was required, in conjunction with the National Academy of Sciences, to conduct a study concerning the questions of using subjective evidence of pain in determining whether a person is under a disability, and the state of the art of preventing, reducing or coping with pain. This study was completed and a report was submitted to the House Committee on Ways and Means and the Senate Committee on Finance in 1986. While making many recommendations, it basically supported the existing treatment of allegations of pain in disability determinations.

The provision also established a statutory standard for considering pain which was in effect until December 31, 1986:

> An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this

section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques which show the existence of a medical impairment that results from anatomical, physiological or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue), must be considered in reaching a conclusion as to whether the individual is under a disability.

3. Multiple impairments

In determining whether a person's impairment or impairments are of a sufficient medical severity to be the basis of a finding of eligibility for benefits, the Secretary was required to consider the combined effect of all of the person's impairments, whether or not any one impairment would alone be severe enough to qualify the person for benefits. The provision became effective for all determinations made on or after 30 days after enactment.

4. Moratorium on mental impairment reviews

A moratorium was imposed on reviews of all cases of mental impairment disability until the mental impairment criteria in the Listing of Impairments were revised to realistically evaluate the person's ability to engage in SGA in a competitive workplace environment. The moratorium applied to all cases on which an administrative or judicial appeal was pending on or after June 7, 1983. All persons claiming benefits based on mental impairment disability who received an unfavorable initial or continuing disability decision after March 1, 1981 were permitted to reapply for benefits within 12 months of enactment. The revised criteria were published in 1985.

5. Pretermination notice

The Secretary was required to initiate demonstration projects on providing face-to-face interviews for (1) pretermination continuing disability cases and (2) for all initial denial cases, in lieu of face-to-face evidentiary hearings at reconsideration, to be done in at least five States with a report due to the House Committee on Ways and Means and the Senate Committee on Finance on April 1, 1986. The Secretary was also required to notify individuals, upon initiating a periodic eligibility review, that termination of benefits could be the result of the review, and that medical evidence may be provided. Although these studies have been completed, the report has not yet been submitted to Congress.

6. Continuation of benefits during appeal

This provision provided for continuation of benefits during appeal for all continuing disability review cases through the decision of the ALJ, at the election of the individual. Where the ALJ's decision is adverse to the individual, these benefits were to be repaid. The provision was made permanent for SSI disability recipients, and applied to DI beneficiaries through December 1987. The Omnibus Budget Reconciliation Act of 1987 extended the provision for DI beneficiaries through December 1988; the 1988 tax technical corrections bill extended the provisions through December 1989; and the Omnibus Budget Reconciliation Act of 1989 extended them through December 1990.

7. Qualifications of medical professionals

This provision required the Secretary to make every reasonable effort, in cases based on mental impairments, to insure that a qualified psychiatrist or psychologist completes the medical portion of the case review and of the residual functional capacity assessment before any determination is made that an individual is not disabled. The Secretary was given the authority to contract directly for such services if the State agency is unable to do so.

8. Standards for consultative examinations/medical evidence

The Secretary was required to promulgate regulations regarding consultative examinations, including when they should be obtained, the type of referral to be made, and the procedures for monitoring the referral process. Further, the Secretary was required to make every effort to obtain necessary medical evidence from the treating physician before evaluating medical evidence from any other source, and to consider all evidence in the case record and development of complete medical history over at least the preceding 12-month period.

9. Administrative procedure and uniform standards

As required, regulations were published setting forth uniform standards for DI and SSI disability determinations under section 553 of the Administrative Procedure Act, to be binding at all levels of adjudication.

10. Nonacquiescence

While the conference agreement dropped both the House and Senate provisions relating to the Secretary's acquiescence with Court rulings, the intent was not to endorse the practice of "nonacquiescence." The conferees noted that questions had been raised about the constitutional basis of the practice, that many of the conferees had strong concerns about the practice, and that a policy of nonacquiescence should be followed only where steps have been taken or are intended to be taken to receive a review of the disputed issue in the Supreme Court. The conferees also urged the Secretary to seek a resolution of the nonacquiescence issue in the Supreme Court.

In January 1990, SSA issued regulations relating to its adherence with circuit court decisions which are in conflict with SSA's policies. Their key provisions are that: (a) SSA will apply a circuit court decision that conflicts with SSA policy, within the circuit and at all levels of administrative adjudication, unless the Government decided to appeal the decision; and (b) SSA will publish in the Federal Register an Acquiescence Ruling explaining how adjudicators should apply the circuit court decision. SSA will also publish all other Social Security Rulings in the Federal Register.

11. Payment of costs of rehabilitation services

The provision permitted reimbursement to State agencies for costs of VR services provided to individuals receiving DI benefits under section 225(b) of the Social Security Act who medically recover while in VR, whether or not the person worked at SGA for 9 months, and whether or not the person failed to cooperate in the program.

12. Direction for Quadrennial Social Security Advisory Council

The provision required the next quadrennial advisory council (as required in the Social Security Act) to study the medical and vocational aspects of disability using ad hoc panels of experts where appropriate. The study was to include alternative approaches to work evaluation for SSI recipients, effectiveness of VR programs, and other disability program policies, standards, and procedures. The Council issued its report in March of 1988.

13. Staff attorneys

The Secretary was to report, within 120 days of enactment, to the House Committee on Ways and Means and the Senate Committee on Finance, on the actions taken by the Secretary to establish positions which enable staff attorneys to gain the qualifying experience and quality of experience necessary to compete for ALJ positions. Statement of managers stated that it was assumed, given U.S. Office of Personnel Management (OPM) actions at the time, that statutory requirements for establishing specific positions were not required, and the Secretary was urged to take all reasonable steps to see that the OPM actions resulted in SSA staff attorneys becoming qualified for GS-15 ALJ positions.

14. SSI benefits for persons working despite impairment

This provision extended Sections 1619 (a) and (b) through June 30, 1987, and required the Secretaries of HHS and Education to establish training programs for staff personnel in SSA district offices and State VR agencies, and disseminate information to SSI applicants, recipients, and potentially interested public and private organizations. Sections 1619 (a) and (b) were made permanent in 1986.

15. Frequency of continuing eligibility reviews

The Secretary was required to promulgate regulations establishing standards for determining the frequency of continuing eligibility reviews. Final regulations were to be issued within 6 months and during that period no individual could be subjected to more than one periodic review.

16. Representative payees for Social Security and SSI beneficiaries

The Secretary was required to (1) evaluate qualifications of prospective payees prior to or within 45 days following certification, (2) establish a system of annual accountability monitoring where payments are made to someone other than a parent or spouse living in the same household with the beneficiary, and (3) report to Congress on implementation, and annually on the number of cases of misused funds and disposition of such cases.

LEGISLATIVE CHANGES IN THE 100TH CONGRESS

Public Law 100-203, the Budget Reconciliation Act of 1987

1. Continuation of benefits during appeal.—The existing provision for continued payment of disability benefits during the administrative appeal process was extended through 1988.

2. Lengthening of the extended period of eligibility for disability benefits.—The extended period of eligibility during which a disability beneficiary who returns to work may become automatically reentitled to benefits, was lengthened from the current 15 months to 36 months. Medicare eligibility is not continued beyond the period provided under current law.

3. Payment of attorneys' fees.—The administrative policy which permits ALJs to authorize attorneys' fees of up to $3,000 without approval by an SSA regional office was reinstated.

Public Law 100-647, the Technical and Miscellaneous Revenue Act of 1988

1. Continuation of benefits during appeal.—The existing provision for continued payment of benefits was again extended, through 1989.

2. Interim benefits in cases of delayed final decisions.—Interim benefits will be paid to individuals who have received a favorable decision from an administrative law judge but whose cases are under review by the Appeals Council and the Council has not rendered a decision within 110 days. These interim payments are not subject to recovery as overpayments if the final determination is unfavorable.

LEGISLATIVE CHANGES IN THE 101ST CONGRESS

Public Law 101-239, the Omnibus Budget Reconciliation Act of 1989

1. Continuation of benefits during appeal.—The existing provision for continued payment of benefits was again extended, through 1990.

2. Extension of disability insurance program demonstration authority.—The authority of the Secretary to waive compliance with the benefit requirements of titles II and XVIII for the purpose of conducting work incentive demonstration projects was extended for 3 years, through June 9, 1993.

3. Representation of claimants.—Effective June 1, 1991, the Secretary would be required to maintain an electronically retrievable list of claimants' legal representatives.

Public Law 101-508, the Omnibus Budget Reconciliation Act of 1990

1. Continuation of benefits during appeal.—The existing provision for continued payment of benefits during appeal was made permanent.

2. Improvement of the definition of disability applied to disabled widow(er)s.—The stricter definition of disability that was previously applied only to widow(er)s was repealed. Instead, a disabled widow(er) is subject to the same definition of disability as is already applied to disabled workers.

3. Creation of a rolling five-year trial work period for all disabled beneficiaries.—Effective January 1, 1992, the current trial work period will be liberalized so that a disabled beneficiary will exhaust this period only after completing 9 trial work months in any 60-month period. In addition, beneficiaries will receive a new trial work period for each period of eligibility.

4. Continuation of benefits on account of participation in a non-State vocational rehabilitation program.—Beneficiaries who medically recover while participating in an approved non-State vocational rehabilitation program are granted the same benefit continuation rights as those who medically recover while participating in a State-sponsored program.

5. Pre-effectuation review of favorable decisions by the Social Security Administration.—The percentage of favorable decisions made by State disability determination services that must be reviewed by SSA was reduced from 65 percent of all such decisions to 50 percent of allowances and a sufficient number of other determinations to maintain a high level of accuracy in such decisions. The reviews are to be targeted on those cases most likely to contain errors.

6. Vocational rehabilitation (VR) demonstration projects.--The Secretary is required to conduct demonstration projects permitting disabled beneficiaries to select a public or private rehabilitation provider which would furnish rehabilitation services aimed at enabling them to engage in substantial gainful activity and to leave the disability rolls. The demonstration projects are to run for 3 years in at least three States. An interim report is due by April 1, 1992, and a final report is due by April 1, 1994.

Section 3. Social Security Financing

OVERVIEW

This section presents an overview of the financing of the old-age, survivors, and disability insurance (OASDI) trust funds and provides a summary of the short- and long-term projections for the financial solvency of these funds under a variety of demographic and economic assumptions.

CURRENT LAW FINANCING

The Social Security programs, or old-age, survivors, and disability insurance and hospital insurance trust funds (OASDHI), are financed through the payroll tax and from income taxes paid on Social Security benefits. Most of current income to the system goes out directly to meet current benefit obligations. Any funds collected in excess of the amount needed to make benefit payments are credited to the trust funds as reserves, in the form of Government securities. These reserves serve as a cushion against temporary shortfalls in revenues or large increases in outlays due to economic fluctuations; the reserves also provide interest income to the trust funds. As a result of the Social Security Amendments of 1983, OASDI reserves are projected to build rapidly in the next quarter century.

Trust fund income is dependent on the amount of wages covered by Social Security on which taxes are levied according to the payroll tax rate for each year. Benefit outlays are made under a permanent appropriation, equal to the amount to which beneficiaries are entitled based on their earnings records, and are not limited to the amount of revenue credited to the trust fund from contributions and interest. If, as occurred in the early 1980's, yearly income is insufficient to cover benefit payments, reserves are used to make up the difference.

The payroll tax is levied on earnings in employment covered by Social Security, with portions of the total tax rate allocated by law to each of the three trust funds (OASI, DI and HI). All persons who work in covered employment pay this mandatory tax on their earnings up to a maximum dollar amount (known as the maximum taxable earnings base, or wage base). Beginning in 1991, there are two separate wage bases, one for the OASDI tax and another for the HI tax. Employers pay an equal tax for these workers. Effective in 1984, self-employed workers began to pay Social Security taxes that were equivalent to the combined employer-employee rate and to receive a partial credit against that tax through 1989. The self-employment credit expired at the end of 1989, but beginning in 1990, self-employment taxes are computed on a lower base and half of the tax is deductible for income tax purposes.

Under current law, as of January 1991, the employer and employee each pay an OASDI tax equal to 6.20 percent of the first $53,400 of earnings and an HI tax equal to 1.45 percent of the first $125,000 of earnings (self-employed persons pay 15.30 percent). In general, increases in the wage base are automatic, based on the increase in average wages in the economy (excluding self-employment earnings) each year.[1] Table 1 summarizes the payroll tax schedule both historically and under the provisions of current law.

TABLE 1.—SELECTED PAYROLL TAX RATE AND WAGE BASE LEVELS, HISTORICALLY AND UNDER CURRENT LAW

	Wage base		Contribution rate (percent) employer/employee each			
	OASDI	HI	Total	OASI	DI	HI
1937	$3,000		1.0	1.0		
1950	3,000		1.5	1.5		
1955	4,200		2.0	2.0		
1959	4,800		2.5	2.25	0.25	
1966	6,600	$6,600	4.2	3.5	.35	0.35
1970	7,800	7,800	4.8	3.65	.55	.60
1974	13,200	13,200	5.85	4.375	.575	.90
1978	17,700	17,700	6.05	4.275	.775	1.00
1979	22,900	22,900	6.13	4.33	.75	1.05
1981	29,700	29,700	6.65	4.70	.65	1.30
1982	32,400	32,400	6.70	4.575	.825	1.30
1984	37,800	37,800	[1] 7.00	5.20	.50	1.30
1985	39,600	39,600	7.05	5.20	.50	1.35
1986	42,000	42,000	7.15	5.20	.50	1.45
1987	43,800	43,800	7.15	5.20	.50	1.45
1988	45,000	45,000	7.51	5.53	.53	1.45
1989	48,000	48,000	7.51	5.53	.53	1.45
1990	[2] 51,300	[2] 51,300	7.65	5.60	.60	1.45
1991	53,400	[3] 125,000	7.65	5.60	.60	1.45
1992–99	(4)	(4)	7.65	5.60	.60	1.45
2000 and after	(4)	(4)	7.65	5.49	.71	1.45

[1] A tax credit of 0.3 percent of taxable wages was allowed in 1984 against the tax paid by employees, so that the effective employee withholding rate was 6.7 percent.

[2] The Omnibus Budget Reconciliation Act of 1989 included an increase in the wage base reflecting the inclusion of certain deferred compensation in the calculation of average wages.

[3] The Omnibus Budget Reconciliation Act created a separate wage base for HI.

[4] Subject to automatic increase. Under CBO assumptions, the OASDI, wage base will be $55,800 in 1992, $58,800 in 1993, $62,700 in 1994, $66,000 in 1995, and $69,600 in 1996.

Source: Social Security Bulletin, Annual Statistical Supplement, 1990, Table 2.A1.

---

[1] Increases in the wage base are triggered whenever cost-of-living adjustments are granted to Social Security beneficiaries and are effective on a calendar year basis.

TABLE 2.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR SELF-EMPLOYED INDIVIDUALS, BY INDIVIDUAL AND COMBINED TRUST FUNDS, 1980 AND AFTER

Calendar year	OASI	DI	OASDI combined	HI	OASDHI combined
1980	6.2725	.7775	7.05	1.05	8.10
1981	7.0250	.9750	8.00	1.30	9.30
1982	6.8125	1.2375	8.05	1.30	9.35
1983	7.1125	.9375	8.05	1.30	9.35
1984	10.4000	1.0000	11.40	2.60	[1] 14.00
1985	10.4000	1.0000	11.40	2.70	[1] 14.10
1986–87	10.4000	1.0000	11.40	2.90	[1] 14.30
1988–89	11.0600	1.0600	12.12	2.90	[1] 15.02
1990–99	11.2000	1.2000	12.40	2.90	15.30
2000 and after	10.9800	1.4200	12.40	2.90	15.30

[1] Excludes tax credits for the self-employed which equaled 2.7 percent in 1984, 2.3 percent in 1985, and 2.0 percent for the years 1986 through 1989. See text for explanation of change in tax treatment of the self-employed.

Source: Social Security Bulletin, Annual Statistical Supplement, 1989.

In 1940, approximately 24 million persons worked in employment covered by the Social Security system. Over the years, major categories of workers were brought under the system, such as State and local government employees (on a voluntary basis), regularly employed farm and domestic workers, members of the armed services, and self-employed professionals such as physicians and lawyers. In 1991, about 134 million workers and 96 percent of all jobs in the United States will be covered under Social Security. The present-law Social Security wage base is updated automatically according to wage increases in the economy. In 1991, 88 percent of all earnings from jobs covered by Social Security are taxable.

While coverage is compulsory for most types of employment, approximately 10 million jobs were exempt from coverage under Social Security in 1987. The majority of these noncovered positions were and still are in the Federal Government and in State and local governments. Beginning January 1, 1983, Federal employees were covered under the Medicare portion of the Social Security tax, and all Federal employees hired after 1983 are covered under the OASDI portion as well. In 1987, about 72 percent of State and local government jobs (10.9 million out of 15.2 million jobs), were covered by Social Security. Beginning January 1, 1984, all employees of nonprofit organizations became covered, and terminations of Social Security coverage by State government entities were no longer allowed.[2] State and local employees hired after March 31, 1986 are mandatorily covered under the Medicare program and must pay HI payroll taxes. Beginning July 1, 1991, State and local employees who are not members of a public retirement system are mandatorily covered under Social Security. This requirement was contained in the 1990 Omnibus Budget Reconciliation Act (OBRA).

---

[2] Terminations were prohibited as of April 1983.

While the most recent year for which actual data are available is 1987, the Social Security Administration estimates that in 1992, 21.7 million individuals will work at some time during the year for a State or local government, and the wages of 77 percent of these individuals will be covered by Social Security. Some 2.4 million of the 16.7 million covered State and local workers are estimated to have been covered as a result of OBRA 1990. Table 4 shows State-by-State data on State and local government jobs covered in 1987.

TABLE 3.—SOCIAL SECURITY COVERAGE, 1987

[In millions]

Occupational group	Number of employees	Covered [1]	
		Number	Percent
Specifically exempt from OASDI coverage:			
Federal Civilian employees [2]	3.6	1.5	41.7
Voluntary coverage:			
State and local government	15.2	10.9	71.7
Mandatorily covered:			
Industry and commerce	88.3	88.1	99.8
Nonprofit [3]	7.3	7.2	98.6
Farm [3]	1.3	1.1	84.6
Domestic [3]	1.3	.5	38.5
Self-employed [3]	9.9	7.5	75.8

[1] Data on covered employment are estimated based upon class of worker of major job in which employed over the year 1987. The figures do not reflect turnover in jobs during the year.

[2] Federal employees who are temporary or who work for quasi-Federal agencies such as TVA are covered. The 1983 Social Security Amendments covered Federal employees hired after 1983, as well as all nonprofit employees, current and future.

[3] Mandatorily covered if special minimum coverage requirements met. Special minimum requirements for coverage generally relate to amount of wages earned—for example, domestic employees must receive at least $50 from one employer during a calendar quarter for those wages to be covered.

Note: Due to the unavailability of more recent data, this table does not reflect changes in coverage enacted since 1987. These changes are described in the text above.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 4.—ESTIMATES OF SOCIAL SECURITY COVERAGE OF WORKERS WITH STATE AND LOCAL GOVERNMENT EMPLOYMENT AS THEIR MAJOR JOB IN 1987 [1]

[Based on 1-percent sample; numbers in thousands]

State	All workers	Covered workers	Percent covered
Total	15,204	10,895	72
Alabama	241	231	96
Alaska	51	22	42
Arizona	204	184	90
Arkansas	142	133	93
California	1,625	646	40
Colorado	207	50	24
Connecticut	194	122	63
Delaware	40	26	65
Florida	684	637	93
Georgia	400	348	87
Hawaii	70	44	63
Idaho	64	64	100
Illinois	646	352	55
Indiana	312	289	93
Iowa	213	209	98
Kansas	185	181	98
Kentucky	214	173	81
Louisiana	292	63	21
Maine	75	32	43
Maryland	286	257	90
Massachusetts	378	15	4
Michigan	592	545	94
Minnesota	292	216	74
Mississippi	161	156	97
Missouri	292	234	80
Montana	61	57	95
Nebraska	118	116	98
Nevada	56	4	7
New Hampshire	54	52	97
New Jersey	498	465	93
New Mexico	115	105	91
New York	1,373	1,197	87
North Carolina	424	396	93
North Dakota	57	52	91
Ohio	646	15	2
Oklahoma	205	190	93
Oregon	191	180	94
Pennsylvania	591	546	92
Rhode Island	46	37	79
South Carolina	232	225	97

TABLE 4.—ESTIMATES OF SOCIAL SECURITY COVERAGE OF WORKERS WITH STATE AND LOCAL GOVERNMENT EMPLOYMENT AS THEIR MAJOR JOB IN 1987 [1]—Continued

[Based on 1-percent sample; numbers in thousands]

State	All workers	Covered workers	Percent covered
South Dakota	52	50	97
Tennessee	264	232	88
Texas	1,003	518	52
Utah	117	107	91
Vermont	39	38	97
Virginia	373	351	94
Washington	327	264	81
West Virginia	113	107	95
Wisconsin	351	319	91
Wyoming	47	46	99

[1] Major job is determined by type of employment of longest job (all workers) and of job with largest amount of covered wages (covered workers).

Note: This table shows the extent of combined OASDI and HI coverage. Data on HI-only coverage are not yet available. Furthermore, it does not reflect changes in coverage enacted since 1987. A discussion of these changes may be found in the text earlier in this section.

Source: Office of Research and Statistics, Social Security Administration.

CURRENT SHORT-RANGE STATUS OF THE TRUST FUNDS

An assessment of the short-range status of the trust funds depends heavily on the economic assumptions underlying the estimates because both the revenues and expenditures of the program are tremendously affected by general economic trends such as unemployment, wage growth, and inflation. Tables 5 and 6 present short-term projections of the financial status of the trust funds under the assumptions contained in the President's fiscal year 1992 budget and the Congressional Budget Office baseline, respectively.

TABLE 5.—CURRENT LAW PROJECTIONS OF THE OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUND OUTLAYS, INCOMES, AND BALANCES ON THE BASIS OF THE PRESIDENT'S FISCAL YEAR 1992 BUDGET ASSUMPTIONS

[By fiscal year, in billions of dollars]

	Fiscal year—						
	1990	1991	1992	1993	1994	1995	1996
Old-age and survivors insurance:							
Total outlays	223.5	241.3	258.8	274.8	289.8	304.5	319.5
Income [1]	278.6	296.0	318.5	344.4	374.2	402.5	434.3
Year-end balance	203.4	258.2	317.9	387.5	471.9	569.9	684.7
Start-of-year balance as percent of outlays [2]	74	92	100	116	134	155	178
Disability insurance:							
Total outlays	25.1	27.4	29.6	31.5	33.3	35.3	37.5
Income [1]	28.2	29.7	32.4	35.3	38.0	40.8	43.9
Year-end balance	11.5	13.8	16.6	20.3	25.1	30.6	36.9
Start-of-year balance as percent of outlays [2]	40	49	47	53	61	71	81
Combined OASI and DI:							
Total outlays	248.6	268.6	288.5	306.3	323.1	339.8	357.0
Income [1]	306.8	325.8	350.9	379.7	412.3	443.3	478.2
Year-end balance	214.9	272.0	334.5	407.8	497.0	600.5	721.7
Start-of-year balance as percent of outlays	71	88	94	109	126	146	168

[1] Income to the trust funds is budget authority, and includes payroll tax receipts, interest on investments, and certain general fund transfers.

[2] Start-of-year balances for OASI and DI are computed as the balances at the end of the previous year plus, for 1990 and 1991 only, the advanced tax transfers at the beginning of the year.

Source: Social Security Administration, Office of the Actuary estimates based on economic assumptions contained in the President's fiscal year 1992 budget.

TABLE 6.—CURRENT LAW PROJECTIONS OF THE OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUND OUTLAYS, INCOMES, AND BALANCES UNDER CBO'S REVISED MARCH 1991 BASELINE SET OF ECONOMIC ASSUMPTIONS

[By fiscal year, in billions of dollars]

	Fiscal year—						
	1990	1991	1992	1993	1994	1995	1996
Old-age and survivors insurance:							
Total outlays	224.5	243.2	257.1	272.1	287.1	302.7	319.0
Income [1]	279.6	301.3	323.7	349.6	378.7	408.9	441.5
Year-end balance	203.4	261.4	328.0	405.5	497.1	603.4	725.9
Start-of-year balance (as percent of outlays) [2]	74	92	102	121	141	164	189
Disability Insurance:							
Total outlays	25.2	28.3	29.7	31.6	33.5	35.6	37.7
Income [1]	28.3	30.7	32.9	35.6	38.2	41.0	44.0
Year-end balance	11.5	13.9	17.1	21.1	25.8	31.3	37.6
Start-of-year balance (as percent of outlays) [2]	41	48	47	54	63	73	83
Combined OASI and DI:							
Total outlays	249.7	271.6	286.8	303.7	320.6	338.2	356.7
Income [1]	307.9	332.0	356.6	385.2	416.9	450.0	485.6
Year-end balance	214.9	275.3	345.1	426.6	522.9	634.7	763.5
Start-of-year balance (as percent of outlays) [2]	71	88	96	114	133	155	178

[1] Income to the trust funds is budget authority, and includes payroll tax receipts, interest on investments, and certain general fund transfers.

[2] Start-of-year balances are computed as the balances at the end of the previous year. For 1990 and 1991, such balances also include advanced tax transfers.

Source: Congressional Budget Office estimates based on January 1991 Economic Assumptions and Revised March 1991 Technical Assumptions.

Status of OASDI trust funds

Under the President's budget as well as CBO baseline assumptions, the combined OASDI trust funds will continue the growth begun in 1984 throughout the 5-year projection period incorporated in the President's and CBO's forecasts. The growth accelerated during 1990 due to the increase in the OASDI portion of the FICA tax rates. The annual excess of revenues over benefit outlays (sometimes called the "surplus") will reach almost $100 billion by 1994. Throughout the 1990's, and for some period into the next century, the favorable demographic pattern of a large baby-boom generation at peak earning years combined with the retirement of the relatively small generation born during the Depression should ensure large trust fund reserves.

For the combined OASDI funds, under the President's budget assumptions, the trust fund reserve ratio is estimated to increase from 71 percent at the beginning of 1990 to 88 percent for 1991, and then continue to increase each year thereafter, reaching 168 percent by 1996. A similar pattern of increase is shown under the CBO baseline assumptions.

Budgetary treatment of OASDI trust funds

Social Security and other Federal programs that operate through trust funds were counted officially in the Federal budget beginning in fiscal year 1969. This was done administratively by President Johnson. At the time Congress did not have a budget-making process. In 1974, Congress began setting budget goals annually through passage of budget resolutions. Like the budgets the President prepared, these resolutions reflected a "unified budget" approach that included trust fund programs such as Social Security in the budget totals. Although Social Security continued to be counted in the budget throughout the 1970s and 1980s, measures were enacted in 1983, 1985, and 1987 making the program a more visible component of the budget and imposing potential procedural hurdles for budgetary bills containing Social Security changes. Most significant among them was the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177), which incorporated the original Gramm-Rudman-Hollings deficit-reduction procedures and contained specific provisions setting forth the budgetary treatment of the OASDI trust funds. The act required that the OASDI trust funds be taken off-budget beginning in fiscal year 1986. (The 1983 Social Security Amendments had previously required that the funds be taken off budget in fiscal year 1993.) However, the act also required that the income and outgo of the OASDI trust funds be taken into account in determining if Federal spending had to be cut to meet the Gramm-Rudman-Hollings deficit-reduction goals. This meant that the OASDI trust funds would be counted in the budget figures throughout the period in which Gramm-Rudman-Hollings was in force. This period was extended for 2 years—from fiscal year 1991 to fiscal year 1993—by the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100-119).

Other provisions of the balanced budget act exempted OASDI benefits from automatic reductions, or so-called sequestration. Thus, while OASDI income and outgo were counted to determine the size of the Federal deficit, OASDI benefits were not subject to automatic reduction if the deficit was too high.[3] The act further included provisions making it "out of order" for either the House or Senate to take up changes in OASDI as part of a budget reconciliation measure. Separate votes in each body—suspending or otherwise altering the rules under which the respective bodies operate—were required to make consideration of any proposed OASDI change permissible. In the Senate, this would require approval by three-fifths of its members.

Social Security also was affected by restrictions in the Act on bringing up legislative changes that would violate budget resolution totals or separate spending and revenue allocations for programs under the jurisdiction of each committee made subsequent to passage of budget resolutions. Social Security was affected by these restrictions in the same way as other programs and tax provisions; points of order (so-called sections 302 and 311 objections) could be raised against legislation involving revenue reductions or spending increases that violated the budget resolution totals or subsequent spending allocations by committees for the first year to which the budget resolution applied. These, too, could be overridden only by a vote of three-fifths of the Senate.

---

[3] However, administrative expenses of the Social Security Administration were subject to sequestration.

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) made major changes in the Federal budget process. Among them was the removal of the Social Security trust funds from all Federal budget calculations, including calculations of budget deficits and surpluses. As a result, OASDI will no longer affect or be affected by limitations caused by Federal deficits or the budget process in general (with the exception of administrative expenses).

The new law establishes new, specific dollar limits on discretionary spending (mostly annual appropriations) and a new "pay-as-you-go" requirement for direct spending (mostly entitlement programs) and revenues. For fiscal years 1991–93, these new limits and the pay-as-you-go requirement will replace the overall deficit-reduction targets established under the former Gramm-Rudman-Hollings procedures. For fiscal years 1994–95, overall deficit targets again will become critical limits. As under the old law, if any spending limit or the "pay-as-you-go" rule is violated, the President may be required to issue sequestration orders bringing spending down to the prescribed limits.

Social Security spending and revenues are excluded from these new limits and overall targets, with the exception of administrative expenditures, which, under an OMB interpretation, are incorporated in a limit on discretionary domestic spending.[4] Social Security is also exempt from sequestration orders, as it was under the old law (again, with the exception of administrative expenses).

Finally, the new law continues the old law provision (section 310(g)) that permits points of order against reconciliation bills that contain Social Security measures.

OASDI tax receipts are expected to exceed benefits and other expenses continuously over the budget forecast period, i.e., the next 5 years. Barring a major recession, the excess receipts should grow substantially. What this means is that, with all other things held constant, surplus OASDI receipts would have offset a substantial portion of the deficits the Government incurs with respect to its other activities if Social Security had continued to be counted in the budget. The following table shows how the removal of the operations of the OASDI trust funds from the budget calculations affected CBO's latest 5-year forecast of Federal budget deficits.

---

[4] Under prior law, Social Security administrative expenses were subject to sequestration if Gramm-Rudman-Hollings deficit targets were exceeded. The new law states that Social Security will not be counted as budget authority or outlays for purposes of the Gramm-Rudman deficit reduction law (which the new law amends). However, it also lists Social Security among the programs subject to the discretionary domestic spending limit. One interpretation of this is that Social Security administrative expenses, as discretionary spending, are subject to the domestic discretionary limit. An alternative interpretation is that the provision excluding Social Security from all purposes of the Gramm-Rudman law exempts these expenses from the discretionary limit. The lack of specificity appears to give OMB latitude to make either interpretation.

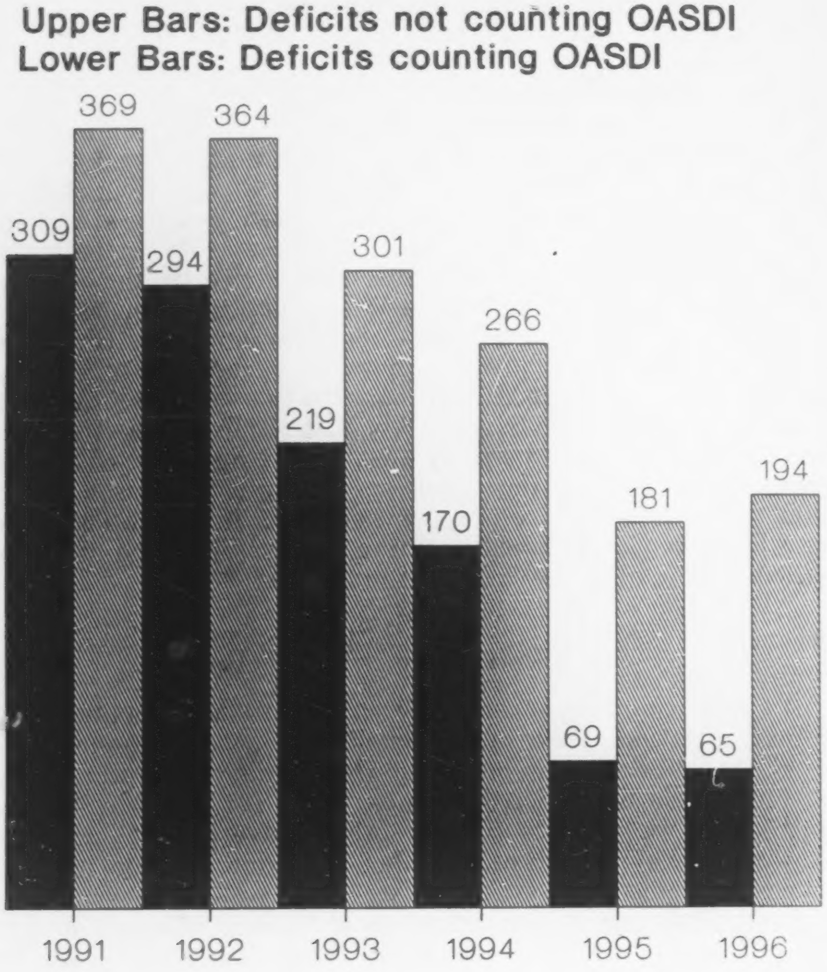
TABLE 7.—PROJECTED FEDERAL BUDGET DEFICITS, INCLUDING AND EXCLUDING OASDI TRUST FUNDS IN THE CALCULATION

Fiscal year	1991	1992	1993	1994	1995	1996
Projected budget deficit:						
Including OASDI	309	294	219	170	69	65
Excluding OASDI	369	364	301	266	181	194
Increase in projected deficit from excluding OASDI	60	70	82	96	112	129

Source: Congressional Research Service. Based on revised "baseline" budget projections prepared by CBO, March 1991.

CHART 1. FEDERAL BUDGET DEFICITS WITH AND WITHOUT OASDI

[Fiscal years; billions of dollars]



Source: Prepared by CRS based on CBO revised "baseline" budget projections, March 1991.

New Procedures to Protect the Trust Funds

Since the fiscal constraints of the budget process now no longer apply to Social Security, the new law establishes separate rules for the House and Senate that make it difficult to bring measures to a floor vote if they would weaken the financial condition of the program.

In the House, a point of order can be raised against a bill that includes more than $250 million in Social Security spending increases or revenue reductions over a 5-year period, unless the bill also contains offsetting spending reductions or tax increases that bring its net impact within the limit. In determining whether a bill falls within the $250 million limit, any costs from prior legislation (i.e., enacted in the current or previous 4 years) that fall within the 5-year budgeting period would be counted. Also, a point of order can be raised against a measure that would increase long-range (75 year) program costs or reduce long-range revenues by at least 0.02 percent of taxable payroll.

In the Senate, budget resolutions must set specific amounts for Social Security income and outgo for the first fiscal year to which the budget resolution applies and cumulative amounts for a 5-year period. These amounts must be completely separate from budget resolution totals. Further, the Social Security income and outgo recommended in budget resolutions reported by the Senate Budget Committee cannot narrow the difference between Social Security income and outgo projected under current law. (Doing so could draw an objection). Once a conference agreement on a budget resolution is reached, allocations made to the Finance Committee must include a Social Security outlay allocation. Budget Act points of order can then be raised against Social Security bills that would cause outlays to be increased or revenues to be reduced (without offsetting changes) from those reflected in the budget resolution and Finance Committee allocation. Overriding such an objection requires a vote of three-fifths of the Senate.

The Impact of the OASDI Surpluses on the Financial Condition of the Government

As attention is increasingly drawn to the surplus OASDI receipts, questions have emerged about how the money is actually used. The basic concern is that the money was intended to be invested in the OASDI trust funds, to be set aside for future years, and not to be used to finance other Government spending today. However, the issue is a complex one and is often confusing and poorly described.

Part of the confusion arises from a lack of understanding that OASDI taxes are not deposited in trust funds and OASDI benefits are not paid from trust funds. OASDI taxes are deposited in the Federal Treasury like other taxes and become part of the general pool of funds through which the Government functions. Airport and highway taxes, civil service retirement contributions, Medicare receipts, and many other forms of dedicated Federal revenues—*all of which have corresponding trust funds*—are treated likewise. The trust funds themselves receive credit for the revenues when the Government receives them, usually in the form of postings of nonmarketable, interest-bearing Federal securities. Conversely, when the Government makes expenditures for trust fund programs, the money is paid from the Treasury, and the securities posted to the trust funds are reduced by a corresponding amount. Simply stated, the OASDI trust funds are given IOUs when OASDI taxes are received by the Treasury, and those IOUs are taken back when the Treasury makes expenditures on the program's behalf. This handling of OASDI's finances goes back to the inception of the program and has not been altered by the inclusion or exclusion of the OASDI trust funds in or from the Federal budget.

In effect, whether or not OASDI is counted as part of the Federal budget, OASDI taxes will continue to be deposited in the Federal Treasury and the trust funds will continue to receive credit for them as they are collected. Moreover, this credit will continue to give the Treasury Department "authority," or what might be described as a "permanent appropriation," to spend for OASDI.[4]

The more fundamental issue about the use of surplus OASDI taxes revolves around perceptions of how the existence of this money will influence Congress and the administration in making future fiscal policy decisions for the Government as a whole. Since surplus OASDI taxes are deposited in the Federal Treasury, there is no way of knowing their ultimate use. In the course of fiscal policymaking, three basic uses can be made of the money: (1) It can be spent on other programs; (2) it can cause other taxes to be lower than they otherwise would be; or (3) it can cause Government borrowing from financial markets to be lower.[5]

It is sometimes stated, ipso facto, that surplus OASDI taxes cause the Government to borrow less from financial markets. However, this perspective represents an oversimplification. The law has always dictated that OASDI trust funds be credited with Federal securities to reflect OASDI tax receipts, but it has never dictated how the surplus receipts themselves are to be used by the Federal Government. The outcome—*what happens to the money*—basically depends on what one assumes fiscal policymakers would decide about spending and taxation for the Government overall if the surplus OASDI taxes were not levied. If levying them influences Congress to avoid cutting spending elsewhere or raising other taxes, Government borrowing from financial markets is not being reduced.

The Government has the potential to increase savings in the economy by reducing the amount of borrowing it does in financial markets. However, this outcome depends on its ability to reduce the difference between its overall income and outgo. It is the Government's net deficit overall that determines how much is really being borrowed from financial markets, not a surplus arising in one of its accounts. All other things held constant, cutting Social Security taxes or increasing Social Security spending would impede efforts to reduce Federal borrowing from financial markets in the same way as any other tax reductions or spending increases, and thereby curtail efforts by the Government to increase savings in the economy.

The long-range impact of the OASDI surpluses

In their 1990 report, the Social Security trustees projected that surplus OASDI taxes would continue until the early years of the post-World War II baby-boom generation's retirement—i.e., until 2015–20. After that, OASDI taxes would fall short of expenditures indefinitely. The program then would have to draw on the IOUs accumulated in its trust funds, and the Government would have to make good on them. In essence, beginning sometime around 2015-20, the Government would no longer have the benefit of surplus OASDI taxes and, in fact, would have to find other resources to cover the trust funds' IOUs. How these resources will be obtained poses a major long-range fiscal policy question. Although the OASDI trust funds would have grown substantially—reaching $2.4 trillion in 2020 as measured in constant 1990 dollars—and would continue to provide authority for the Treasury Department to keep spending for the program until almost the middle of the next century, the trust funds themselves will not provide the resources to pay the benefits. They simply give the Social Security system a claim on other Government resources. What this means in practice is that when the trust funds' IOUs are needed because OASDI tax receipts fall below expenditures, the Government will have to raise other taxes, curtail other expenditures, or increase its borrowing from the public.

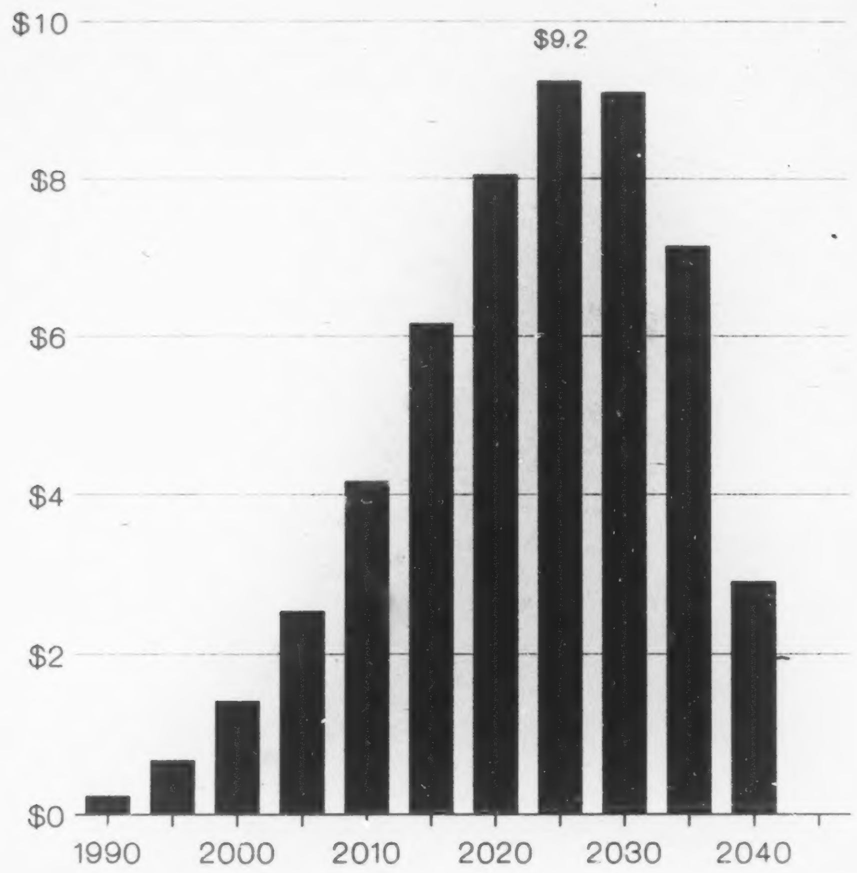
---

[4] Meaning that as long as there are securities posted to the OASDI trust funds, the Treasury Department can continue to make OASDI expenditures.

[5] While the Government is said to "borrow" these surplus receipts, technically, it is crediting one of its accounts and debiting another—i.e., borrowing money from itself.

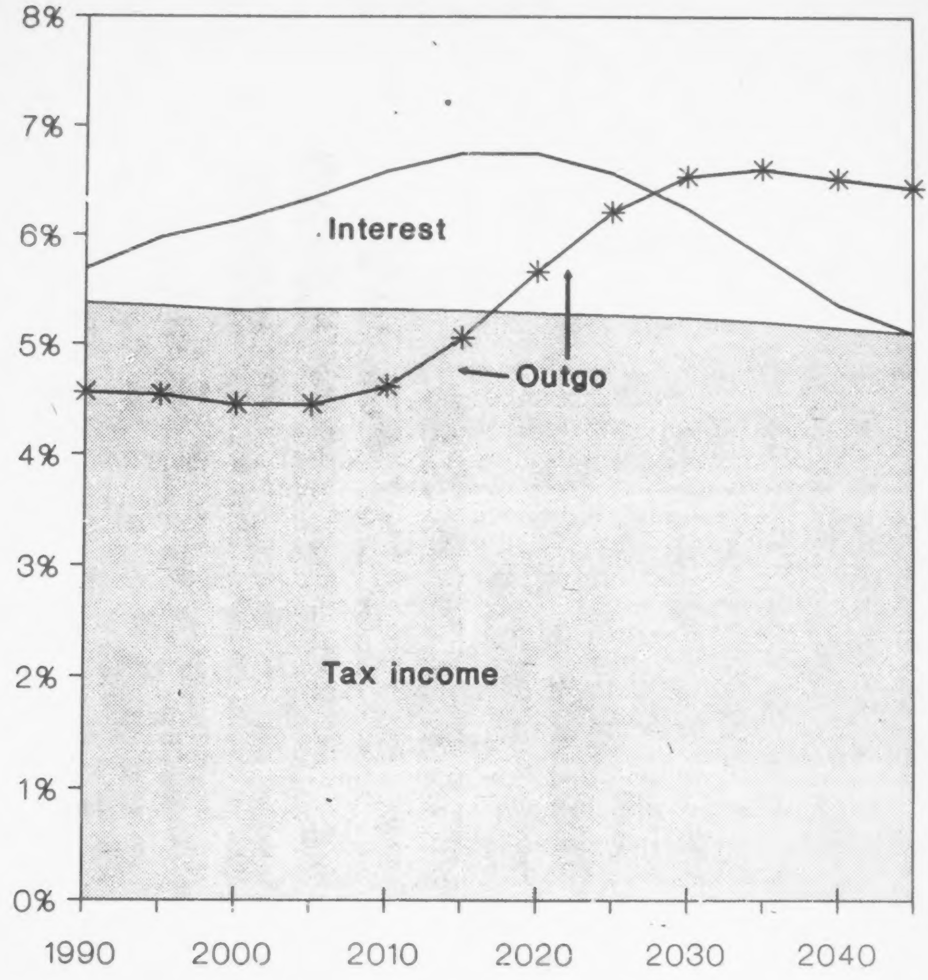
CHART 2. PROJECTED OASDI TRUST FUND BALANCES 1990–2046, IN NOMINAL DOLLARS

[Dollars in trillions]



The combined OASI and DI trust funds are estimated to become exhausted in 2043.
Source: CRS based on 1990 OASDI Trustees' report, Intermediate II-B Forecast

CHART 3. PROJECTED OASDI INCOME AND OUTGO 1990–2045, AS PERCENT OF GNP



Source: Prepared by CRS based on 1990 OASDI Trustees' report, Intermediate II-B Forecast.

Economists argue that if the surplus OASDI taxes arising over the next few decades were to result in a reduction in Government borrowing from the public, more money would exist in investment markets, which could lead to greater economic growth. If this were to occur, extracting resources from the economy in the future to honor the OASDI claims would not necessarily be burdensome. Said another way, if one accepts the premise that reductions in the unified budget deficit today will lead to economic growth by increasing the amount of resources available for investment, then surplus OASDI taxes today could aid in building a higher economic base in the future from which to draw the resources to pay future OASDI benefits.

Even if fiscal policy decisions do lead to enhanced savings, and the Nation's growth rate is augmented in the coming decades, OASDI costs would grow automatically with the economy. In essence, larger OASDI claims would accompany greater economic growth (since that growth would manifest itself in higher wages and entitlement to larger benefits). Further, the post-World War II baby-boom generation and future retirees will raise financial demands across the board, not just for OASDI, as the ratio of workers to retirees falls in the next century. The goods and services to be consumed by society cannot be stockpiled in advance, and the economy will have to adjust. Whether this would be a mild or severe adjustment is largely conjecture, but the manner in which retirement claims are accumulated (publicly or privately) does not necessarily determine it. It may revolve just as much on how the future elderly feel about retiring versus working. No matter how much nominal wealth can be cashed in to produce given levels of retirement income, the amount of goods and services that can be furnished will depend heavily on the proportion of the population able and willing to do the furnishing.

LONG RANGE STATUS OF THE TRUST FUNDS

OASDI trust funds

Because the Social Security program has been designed as a contributory system in which those who pay the taxes supporting it are considered to be earning the right to future benefits, Congress has traditionally required long-range estimates of the program's actuarial balance and has set future tax rates with a view to assuring that the income of the program will be sufficient to cover its outgo. Under current procedures, the long-range actuarial analysis of the cash benefits program covers a 75-year period—this would generally be long enough to cover the anticipated retirement years of those currently in the work force.

The long-range status of the Social Security trust funds is ordinarily expressed in terms of "percent of taxable payroll" rather than in dollar amounts. This permits a direct comparison between the tax rate actually in the law and the cost of the program. For example, if the program is projected to have a deficit of "1 percent of taxable payroll," this means that the Social Security tax rates now in the law would have to be increased by 0.5 percent points for employee and employer, each, in order to pay for the benefits due under present law. (Alternatively, the program could be brought back into balance by an equivalent reduction in benefit outgo or by a combination of revenue increases and outgo reductions.) If the program is projected to have a deficit of 1.5 percent of taxable payroll and expenditures are projected to be 10 percent of taxable payroll, then, under the given set of assumptions, 15 percent (1.5 divided by 10) of expenditures could not be met with that tax schedule. In 1991, the total taxable payroll is estimated to be $2.5 trillion so that in 1991 terms, 1.5 percent of payroll represented about $37.5 billion.

In the short range, the financial soundness of each of the trust funds can be assessed by considering the size of the trust fund balance, in absolute terms and as a percentage of the annual expenditures, and whether the balance is growing or declining. In the long range, the traditional measure of financial soundness has been the actuarial balance of the system. The actuarial balance is defined as the difference between the total income rate and the total cost rate.

Projections of the long-range financial condition of the Social Security programs are affected by three basic types of long-range factors: (1) demographic factors such as rates of fertility, life expectancy, and labor force participation which determine how many workers there will be in the society in relation to nonworking beneficiaries; (2) economic factors such as unemployment, productivity, and inflation; and (3) Social Security program factors, such as benefit levels, total number of covered workers, and percent of eligible workers drawing early retirement benefits.

In projecting the long-term condition of the OASDI trust funds, the actuaries at the Social Security Administration employ four sets of alternative economic and demographic assumptions. Alternative I is based on optimistic assumptions, alternatives II–A and II–B on moderate assumptions, and alternative III on pessimistic assumptions. In general, alternative II–B is considered the most balanced estimate of long-term solvency.

It is clear that these factors cannot be predicted with any certainty as far into the future as 75 years, and the long-range projections should not be taken as absolute predictions of deficits or surpluses in the funds.

Table 8 shows a comparison of the estimated cost rate with the estimated income rate for selected years from 1990 through 2065. The income rate is the sum of the scheduled tax rate and the income from taxation of benefits expressed as a percentage of taxable payroll. On the basis of the 1990 alternative II–B assumptions, estimated income will exceed the estimated cost of the program through the second decade of the next century. After the year 2016, income from scheduled payroll taxes and from the taxation of benefits will not be large enough to cover estimated annual costs, although the accumulated trust fund balance is projected to be sufficient to allow the program to continue operating satisfactorily for many years. The average actuarial balances are estimated to be a surplus of 1.84 percent of taxable payroll for the first 25 years of the long-range projection period; a deficit of 2.18 percent for the second 25 years; and a deficit of 3.75 percent in the third 25 years.

Table 9 shows the estimates of OASI and DI trust fund ratios for each year from 1981 through 2060. As a percent of annual expenditures, the combined assets of the OASI and DI trust funds are estimated to grow until the latter part of the second decade in the next century, reaching levels of about 476 percent of annual expenditures in 2014. Thereafter, the combined trust fund ratios decline steadily until 2043, when the trust fund balances would be exhausted.

The trust fund ratio for OASI exhibits a similar pattern—increasing to about 535 percent in the second decade of the next century and declining thereafter until the trust fund is exhausted in

2047. The DI trust fund increases to about 186 percent of annual expenditures by the first decade of the next century and declines to exhaustion by the year 2021.

Table 10 shows the income rates for the OASI and DI trust funds from two sources: (1) taxable payroll and (2) taxation of benefits. Table 11 shows sources of income to the OASI and DI trust funds expressed in billions of dollars and as a percentage of total income to the trust funds.

Beginning with the 1988 trustees report, the Social Security trustees used an alternative method of determining actuarial balance. Under the "present value" method, interest earnings on the fund are more fully recognized. Calculations were based on the present value of future income, outgo and taxable payroll by discounting the future annual amounts at an assumed rate of interest.

Another major change in valuing the system was made in the 1989 trustees report. Prior to the 1989 report, the trustees based their conclusion about the long-range actuarial condition of the program on the "closeness" of the income and cost rates *when averaged over a 75-year period.* If the income rate was between 95 and 105 percent of the cost rate over this projection period, the system was said to be in close actuarial balance. This definition of actuarial balance was not used in the 1989 report in reaching a conclusion, and the trustees' failure to do so drew an "objection" from SSA's chief actuary, who stated in his "actuarial opinion" of the report: "The decision of the Board * * * to eliminate the explicit test of 'close actuarial balance' should, in my opinion, be reconsidered. * * * Although 'close actuarial balance' cannot characterize all aspects of the actuarial status of the program, in my professional opinion, it should continue to be used as the primary test of the long-range actuarial soundness of the program. For these reasons, I am qualifying my certification statement for this annual report."

While there is some controversy within the actuarial profession about the switch from a level financing to a present value method of measuring the system's actuarial status, the present value method was employed again in the 1990 trustees' report, its third year of use. However, the trustees appear to have reconsidered their abandonment in the 1989 report of the close actuarial balance concept. Although not making a recommendation to the Congress based on the failure of the system's summarized income rate to fall with 95 percent of its summarized cost rate, their conclusion does acknowledge—in contrast to the conclusion in the 1989 report—that the summarized deficit exceeds 5 percent of the cost of the system under the intermediate II-B forecast. Their conclusion states:

> The Board notes that, as in the last annual report, the long-range income rate based on the alternative II-B assumptions is less than 95 percent of the long-range cost rate. The program has traditionally been considered to be adequately financed over the next 75 years when the long-range income rate is between 95 percent and 105 percent of the long-range cost rate. However, because the estimates based on the same assumptions show that the program is solvent for several decades into the future, the Trustees do not recommend that any immediate action be taken to change either the financing or the benefit provisions for the OASDI program. The Board believes that the implications of the expected large buildup of the trust funds and possible ways of addressing the deficits projected for distant future years should continue to be the subject of extensive study. The current Advisory Council on

Social Security is examining these issues and is scheduled to report its recommendations in January 1991.

The chief actuary was more explicit about the actuarial imbalance in his actuarial opinion of the report, stating:

> As indicated in the report, the income rate for the OASDI program over the next 75 years (including the beginning trust fund balances) is equal to 93.5 percent of the cost rate, based on the alternative II-B assumptions. Traditionally, the program has been considered to be in "close actuarial balance" when the long-range income rate (including the beginning trust fund balances) is between 95 percent and 105 percent of the long-range cost rate. A statement on whether or not the OASDI program was in close actuarial balance was included in each annual report from the late 1950's through 1988. Because the income rate (including beginning trust fund balances) is only 93.5 percent of the cost rate, based on the alternative II-B assumptions in this report, the OASDI program is not in close actuarial balance.

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) included a requirement that the trustees' report contain a finding as to whether the Social Security trust funds are in close actuarial balance, as defined by the Board of Trustees.

TABLE 8.—ESTIMATED LONG-RANGE OASDI ANNUAL INCOME RATE, COST RATE, AND ACTUARIAL BALANCE UNDER THE PROGRAM BASED ON ALTERNATIVE II–B OF THE 1990 TRUSTEES' REPORTS

[Percent of taxable payroll]

Year	Income rate [1]			Cost rate			Balance [2]		
	OASI	DI	OASDI	OASI	DI	OASDI	OASI	DI	OASDI
1990	11.40	1.21	12.61	9.54	1.06	10.60	+1.86	+.15	+2.01
1991	11.39	1.21	12.60	9.58	1.07	10.64	+1.81	+.14	+1.96
1992	11.40	1.21	12.61	9.59	1.07	10.67	+1.80	+.14	+1.94
1993	11.40	1.21	12.61	9.61	1.08	10.69	+1.79	+.13	+1.92
1994	11.41	1.21	12.62	9.60	1.09	10.69	+1.81	+.12	+1.93
1995	11.41	1.21	12.62	9.57	1.10	10.67	+1.84	+.11	+1.95
1996	11.41	1.21	12.62	9.51	1.11	10.63	+1.90	+.10	+2.00
1997	11.41	1.21	12.62	9.46	1.13	10.59	+1.95	+.08	+2.03
1998	11.41	1.21	12.63	9.41	1.15	10.56	+2.00	+.06	+2.06
1999	11.41	1.21	12.63	9.37	1.17	10.54	+2.04	+.04	+2.09
2000	11.21	1.43	12.65	9.36	1.20	10.56	+1.85	+.24	+2.09
2005	11.29	1.44	12.74	9.24	1.35	10.59	+2.05	+.09	+2.14
2010	11.37	1.45	12.82	9.52	1.56	11.08	+1.85	−.11	+1.74
2015	11.43	1.46	12.89	10.56	1.70	12.25	+.88	−.24	+.64
2020	11.52	1.46	12.98	12.09	1.77	13.86	−.57	−.31	−.88
2025	11.60	1.46	13.06	13.46	1.87	15.33	−1.86	−.41	−2.27
2030	11.65	1.46	13.12	14.43	1.85	16.28	−2.77	−.39	−3.16
2035	11.68	1.46	13.14	14.80	1.81	16.62	−3.12	−.35	−3.47
2040	11.68	1.46	13.15	14.73	1.82	16.55	−3.04	−.36	−3.40
2045	11.68	1.46	13.15	14.62	1.89	16.52	−2.94	−.43	−3.37
2050	11.69	1.47	13.16	14.77	1.93	16.70	−3.07	−.47	−3.54
2055	11.71	1.47	13.18	15.06	1.94	17.00	−3.35	−.47	−3.82
2060	11.73	1.47	13.19	15.31	1.92	17.23	−3.58	−.45	−4.04
2065	11.73	1.47	13.20	15.44	1.92	17.36	−3.71	−.45	−4.16
25-year subperiods: [3]									
1990–2014	11.33	1.34	12.67	9.53	1.30	10.83	+1.80	+.04	+1.84
2015–2039	11.57	1.46	13.02	13.38	1.82	15.20	−1.82	−.36	−2.18
2040–2064	11.68	1.46	13.14	14.97	1.91	16.89	−3.30	−.45	−3.75
Valuation periods: [4]									
25 years: 1990–2014	11.63	1.36	12.99	9.53	1.30	10.83	+2.11	+.06	+2.17
50 years: 1990–2039	11.60	1.40	13.01	11.30	1.54	12.83	+.30	−.13	+.17
75 years: 1990–2064	11.62	1.42	13.04	12.31	1.64	13.95	−.69	−.22	−.91

---

[1] The income rate is the sum of the combined employer-employee contribution rate and the income from the Federal income taxation of benefits.

[2] A positive balance indicates a surplus; a negative balance indicates a deficit.

[3] Income rates do not include beginning trust fund balances.

[4] Income rates include beginning trust fund balances.

Source: Office of the Actuary, Social Security Administration; and 1990 OASDI Trustees' report.

TABLE 9.—ESTIMATED LONG-RANGE OASI AND DI TRUST FUND RATIOS

[In percent]

Year	OASI	DI	OASDI	Year	OASI	DI	OASDI
1981	18	21	18	2021	484	(1)	[2] 424
1982	15	17	15	2022	470	(1)	[2] 410
1983	15	14	14	2023	455	(1)	[2] 395
1984	20	35	21	2024	439	(1)	[2] 379
1985	24	27	24	2025	422	(1)	[2] 362
1986	28	38	29	2026	405	(1)	[2] 344
1987	30	44	31	2027	387	(1)	[2] 326
1988	41	38	41	2028	368	(1)	[2] 308
1989	59	38	57	2029	348	(1)	[2] 289
1990	78	41	74	2030	329	(1)	[2] 270
1991	98	54	94	2031	309	(1)	[2] 250
1992	118	68	113	2032	289	(1)	[2] 231
1993	138	81	132	2033	269	(1)	[2] 211
1994	159	93	153	2034	250	(1)	[2] 191
1995	181	105	173	2035	230	(1)	[2] 172
1996	204	114	194	2036	210	(1)	[2] 152
1997	227	122	216	2037	191	(1)	[2] 132
1998	250	128	237	2038	171	(1)	[2] 112
1999	274	132	258	2039	152	(1)	[2] 92
2000	298	136	280	2040	132	(1)	[2] 72
2001	320	152	301	2041	113	(1)	[2] 52
2002	342	165	321	2042	93	(1)	[2] 32
2003	364	176	341	2043	74	(1)	[2] 12
2004	386	183	361	2044	54	(1)	(1)
2005	408	186	379	2045	34	(1)	(1)
2006	429	186	397	2046	14	(1)	(1)
2007	451	184	415	2047	(1)	(1)	(1)
2008	470	179	430	2048	(1)	(1)	(1)
2009	488	172	443	2049	(1)	(1)	(1)
2010	503	163	455	2050	(1)	(1)	(1)
2011	516	153	464	2051	(1)	(1)	(1)
2012	526	142	471	2052	(1)	(1)	(1)
2013	532	129	475	2053	(1)	(1)	(1)
2014	535	116	476	2054	(1)	(1)	(1)
2015	535	102	475	2055	(1)	(1)	(1)
2016	532	88	472	2056	(1)	(1)	(1)
2017	527	72	466	2057	(1)	(1)	(1)
2018	519	56	458	2058	(1)	(1)	(1)
2019	509	40	448	2059	(1)	(1)	(1)
2020	497	23	436	2060	(1)	(1)	(1)

[1] The fund is projected to be exhausted.

[2] Because the DI fund is exhausted, these ratios are theoretical and are shown for information purposes only.

Note: The above estimates are based on the 1990 alternative II–B assumptions. The trust fund ratio is defined as the ratio of the trust fund balance at the beginning of the year to the outgo during the year. After 1983, ratios reflect the inclusion of advance tax transfers for January. These estimates reflect the repayment in 1986 of the remainder ($10.6 billion) of the $12.4 billion borrowed by OASI from HI in 1982.

Source: 1990 Annual Report of the Board of Trustees.

TABLE 10.—ESTIMATED INCOME RATES BY TRUST FUND, ALTERNATIVE II–B, CALENDAR YEARS 1990–2065

[As a percentage of taxable payroll]

Calendar year	OASI			DI			Total		
	Payroll tax	Taxation of benefits	Total	Payroll tax	Taxation of benefits	Total	Payroll tax	Taxation of benefits	Total
1990	11.20	0.20	11.40	1.20	0.01	1.21	12.40	0.21	12.61
1991	11.20	.19	11.39	1.20	.01	1.21	12.40	.20	12.60
1992	11.20	.20	11.40	1.20	.01	1.21	12.40	.21	12.61
1993	11.20	.20	11.40	1.20	.01	1.21	12.40	.21	12.61
1994	11.20	.21	11.41	1.20	.01	1.21	12.40	.22	12.62
1995	11.20	.21	11.41	1.20	.01	1.21	12.40	.22	12.62
1996	11.20	.21	11.41	1.20	.01	1.21	12.40	.22	12.62
1997	11.20	.21	11.41	1.20	.01	1.21	12.40	.22	12.62
1998	11.20	.21	11.41	1.20	.01	1.21	12.40	.23	12.63
1999	11.20	.21	11.41	1.20	.01	1.21	12.40	.23	12.63
2000	10.98	.23	11.21	1.42	.01	1.43	12.40	.25	12.65
2005	10.98	.31	11.29	1.42	.02	1.44	12.40	.34	12.74
2010	10.98	.39	11.37	1.42	.03	1.45	12.40	.42	12.82
2015	10.98	.45	11.43	1.42	.04	1.46	12.40	.49	12.89
2020	10.98	.54	11.52	1.42	.04	1.46	12.40	.58	12.98
2025	10.98	.62	11.60	1.42	.04	1.46	12.40	.66	13.06
2030	10.98	.67	11.65	1.42	.04	1.46	12.40	.72	13.12
2035	10.98	.70	11.68	1.42	.04	1.46	12.40	.74	13.14
2040	10.98	.70	11.68	1.42	.04	1.46	12.40	.75	13.15
2045	10.98	.70	11.68	1.42	.04	1.46	12.40	.75	13.15
2050	10.98	.71	11.69	1.42	.05	1.47	12.40	.76	13.16
2055	10.98	.73	11.71	1.42	.05	1.47	12.40	.78	13.18
2060	10.98	.75	11.73	1.42	.05	1.47	12.40	.79	13.19
2065	10.98	.75	11.73	1.42	.05	1.47	12.40	.80	13.20

Source: 1990 Annual Report of the Board of Trustees.

TABLE 11.—INCOME TO THE OASI AND DI TRUST FUNDS FOR SELECTED FISCAL YEARS

[Dollars in millions]

	Fiscal year [1]						
	1970	1975	1980	1985	1990	1991 [2]	1995 [2]
OASI:							
Net contributions	$29,955	$56,017	$97,608	$175,305	$261,506	$274,349	$359,481
Income from taxation of benefits				3,151	2,924	5,216	6,614
Payments from the general fund	442	447	557	105	34	−2,286	9
Net interest	1,350	2,292	1,886	1,321	14,143	18,767	36,422
Total	31,746	58,757	100,051	179,881	278,607	296,047	402,526
DI:							
Net contributions	4,141	7,356	16,805	16,876	27,291	29,342	38,522
Income from taxation of benefits				218	158	174	374
Payments from the general fund	16	52	118			−772	
Net interest	223	512	453	890	766	997	1,904
Total	4,380	7,920	17,376	17,984	28,215	29,741	40,799
Grand total—OASI and DI	36,126	66,677	117,427	197,865	306,822	325,788	443,325

[1] Under the Congressional Budget Act of 1974, fiscal years 1977 and later consist of the 12 months ending on September 30 of each year. Fiscal years prior to 1977 consist of the 12 months ending on June 30 of each year.

[2] Based on the President's fiscal year budget assumptions.

Source: Office of the Actuary, Social Security Administration.

Economic and Demographic Assumptions

The following tables provide specific information concerning the economic and demographic assumptions which underlie the Social Security trustees' short and long-run financial projections.

TABLE 12.—ECONOMIC ASSUMPTIONS, 1960–2065

Calendar year	Average annual percentage increase in—			Real-wage differential [3] (percent)	Average annual unemployment rate [4] (percent)
	Real GNP [1]	Average wages in covered employment	Consumer Price Index [2]		
Past experience:					
1960–64	3.9	3.4	1.3	2.1	5.7
1965–69	4.4	5.4	3.4	2.0	3.8
1970–74	2.4	6.3	6.1	.1	5.4
1975	−1.3	6.7	9.2	−2.5	8.5
1976	4.9	8.7	5.7	3.0	7.7
1977	4.7	7.3	6.5	.8	7.1
1978	5.3	9.7	7.6	2.1	6.1
1979	2.5	9.8	11.4	−1.6	5.8
1980	−.2	9.0	13.5	−4.5	7.1
1981	1.9	9.7	10.2	−.6	7.6
1982	−2.5	6.5	6.0	.5	9.7
1983	3.6	5.0	3.0	2.0	9.6
1984	6.4	[5] 7.2	3.4	[5] 3.8	7.5
1985	3.0	[5] 4.3	3.5	[5] .8	7.2
1986	3.4	[5] 4.3	1.6	[5] 2.8	7.0
1987	3.7	[5] 5.0	3.6	[5] 1.4	6.2
1988	4.4	[5] 5.1	4.0	[5] 1.1	5.5
1989	2.9	[5] 6.3	4.8	[5] 1.5	5.3
Alternative II–B:					
1990	1.9	5.6	4.4	1.2	5.5
1991	2.4	5.5	4.5	1.0	5.6
1992	2.4	5.5	4.5	1.0	5.6
1993	2.1	5.4	4.3	1.1	5.6
1994	2.2	5.5	4.2	1.4	5.7
1995	2.3	5.4	4.0	1.4	5.7
1996	2.3	5.4	4.0	1.4	5.7
1997	2.3	5.5	4.0	1.5	5.8
1998	2.3	5.4	4.0	1.4	5.8
1999	2.3	5.4	4.0	1.4	5.8
2000	1.8	5.4	4.0	1.3	6.0
2010 and later	[6] 1.8	5.3	4.0	1.3	6.0

---

[1] The real GNP (gross national product) is the total output of goods and services, expressed in 1982 dollars.

[2] The Consumer Price Index is the average of the 12 monthly values of the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI–W).

[3] The real-wage differential is the difference between the percentage increases, before rounding, in (1) average annual wages in covered employment, and (2) the average annual Consumer Price Index.

[4] Through 1999, the rates shown are crude civilian unemployment rates. After 1999, the rates are total rates (including military personnel), adjusted by age and sex based on the estimated total labor force on July 1, 1989.

[5] Preliminary.

[6] This value is for 2010. The annual percentage increase in real GNP is assumed to continue to change after 2010 to reflect the dependence of labor force growth on the size and age-sex distribution of the population. The increase for 2065 is 1.5 for alternative II–B.

Source: Office of the Actuary, Social Security Administration.

TABLE 13.—MAJOR LONG-TERM DEMOGRAPHIC AND LABOR FORCE PARTICIPATION ASSUMPTIONS

[1990 trustees' report II–B assumptions]

FERTILITY RATES

	1917	1933	1947	1957	1976	1981	1995	2015+
Children born per woman in her lifetime	3.33	2.17	3.18	3.68	1.74	1.83	1.93	1.90

LIFE EXPECTANCIES

[Using mortality for calendar year]

	1900	1940	1960	1980	2000	2020	2060
Male:							
At birth	46.4	61.4	66.7	69.9	72.6	74.7	77.0
Age 65	11.3	11.9	12.9	14.0	15.6	16.4	18.0
Female:							
At birth	49.0	65.7	73.2	77.5	79.9	81.3	83.6
Age 65	12.0	13.4	15.9	18.4	19.5	20.4	22.1

PERCENTAGE OF THOSE BORN WHO CAN EXPECT TO REACH AGE 65

[Using mortality for calendar year]

	1900	1940	1960	1980	2000	2020	2060
Male	37.3	55.5	63.8	70.5	75.6	79.6	82.6
Female	41.0	65.4	78.2	83.4	86.6	88.3	90.2

LABOR FORCE PARTICIPATION RATES

[Age adjusted]

[In percent]

	1981	1985	1990	1995	2000	2060
Male	77.9	77.0	76.6	75.9	75.3	74.4
Female	52.0	54.5	57.7	59.0	59.2	58.4

COVERED WORK FORCE—NUMBER OF BENEFICIARIES AND DEPENDENCY RATES

	1960	1980	2000	2020	2040
Total population (in millions)	190	235	279	309	323
Covered workers	73	112	143	151	151
Beneficiaries (OASI and DI)	14	35	44	64	80
Aged dependency ratio [1]	.173	.195	.212	.289	.388
Total dependency ratio [2]	.904	.753	.678	.703	.805
Worker/beneficiary ratio	5.1	3.2	3.2	2.4	1.9

[1] Ratio of persons aged 65 and over to the number of persons aged 20–64.

[2] Ratio of nonworking age to working-age population—population under 20 plus population 65 and over divided by population 20–64.

PERCENT OF INSURED WORKERS DRAWING BENEFITS [1]

	1980	1990	2000	2010	2020	2030 [2]
62–64:						
Male	53.8	59.3	58.1	55.3	55.9	56.2
Female	69.4	71.2	69.1	66.7	65.3	64.7
65–69:						
Male	91.4	92.6	90.8	85.0	84.5	83.1
Female	97.2	96.5	91.1	89.8	88.6	87.3

[1] Includes all retired-worker beneficiaries, all disabled-worker beneficiaries and those widow(er) beneficiaries who would be retired-worker beneficiaries if they were to file claims.

[2] For years beyond 2030 (the last year of phase-in to a normal retirement age of 67), the figures show only small fluctuations.

SENSITIVITY OF LONG-TERM PROJECTIONS

Long-range estimates of the financial status of the OASDI trust funds are extremely sensitive to the basic social, economic, and demographic variables that underpin the projections. Slight variations in assumptions about future demographic or economic trends can lead to substantially different financial projections, and thus any longer term estimate is necessarily very uncertain. In general terms, the income to the funds crucially depends on long-run trends in covered wages paid to employees, which in turn depends on many fundamental economic and demographic factors, such as real wage growth in the economy, fluctuations in the size of the work force, productivity, and overall rates of fertility and immigration. The expenditures of the program depend on the amount of benefits that are paid, which is of course affected by the level of consumer inflation, changes in mortality rates and life expectancy, disability incidence, and work and retirement patterns among the elderly population.

As a way of illustrating the sensitivity of long-term projections to variations in basic assumptions, table 14 presents data on the effects of varying assumptions about real wage growth in the alternative II–B estimates. As the table shows, the assumption that real wage growth will equal 0.8 percent leads to a long-range deficit of 1.43 percent of taxable payroll, as compared to real wage growth of 2.2 percent, which would yield a long-term surplus of 0.03 percent of taxable payroll. This table is based on the premise that all other alternative II–B demographic and economic assumptions are held constant. (Under alternative II–B, the real wage growth assumption is 1.3 percent.)

TABLE 14.—ESTIMATED OASDI AVERAGE INCOME RATES, COST RATES, AND BALANCES, BASED ON ALTERNATIVE II–B WITH VARIOUS REAL-WAGE ASSUMPTIONS

[As a percentage of taxable payroll]

Calendar years	Ultimate percentage increase in wages-CPI [1]			
	4.8–4.0	5.3–4.0	5.7–4.0	6.2–4.0
Income rate:				
25-year: 1990–2014	13.02	12.99	12.97	12.95
50-year: 1990–2039	13.04	13.01	12.98	12.95
75-year: 1990–2064	13.08	13.04	13.01	12.98
Cost rate:				
25-year: 1990–2014	11.18	10.83	10.55	10.20
50-year: 1990–2039	13.34	12.83	12.44	11.94
75-year: 1990–2064	14.51	13.95	13.51	12.95
Balance:				
25-year: 1990–2014	+1.83	+2.17	+2.43	+2.75
50-year: 1990–2039	−.30	+.17	+.54	+1.00
75-year: 1990–2064	−1.43	−.91	−.49	+.03

[1] The first value in each pair is the assumed ultimate annual percentage increase in average wages in covered employment. The second value is the assumed ultimate annual percentage increase in the Consumer Price Index. The difference between the two values is the real-wage differential.

Source: 1990 Trustees' Report.

Tables 15 and 16 provide information on the effects of varying two other key assumptions in estimating long-term financial solvency. Table 15 shows the impact of choosing among alternative assumptions of the ultimate total fertility rate in the general population. As the table demonstrates, a total fertility rate of 1.6 percent leads to a long-run deficit of 1.42 percent of taxable payroll, while a 2.2 percent fertility rate generates a deficit of 0.43 percent of taxable payroll. The middle estimate, 1.9 percent, is employed in the alternative II–B projections.

TABLE 15.—ESTIMATED OASDI AVERAGE INCOME RATES, COST RATES, AND BALANCES, BASED ON ALTERNATIVE II–B WITH VARIOUS FERTILITY ASSUMPTIONS

[As a percentage of taxable payroll]

Calendar years	Ultimate total fertility rate [1]		
	1.6	1.9	2.2
Average income rate:			
25-year: 1990–2014	12.99	12.99	12.99
50-year: 1990–2039	13.01	13.01	13.00
75-year: 1990–2064	13.07	13.04	13.02
Average cost rate:			
25-year: 1990–2014	10.80	10.83	10.85
50-year: 1990–2039	12.96	12.83	12.72
75-year: 1990–2064	14.49	13.95	13.44
Balance:			
25-year: 1990–2014	+2.19	+2.17	+2.14
50-year: 1990–2039	+.06	+.17	+.28
75-year: 1990–2064	−1.42	−.91	−.43

[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year, and if she were to survive the entire child-bearing period. The ultimate total fertility rate is assumed to be reached in 2014.

Source: 1990 Trustees' Report.

Table 16 displays the effects of varying the death-rate assumptions in the alternative II–B estimate. The assumption that the age-sex-adjusted death rate will drop by 18 percent over the period 1990 through 2064 leads to a 0.25 percent deficit in taxable payroll in the long run, while a 50 percent drop in the death rate produces a deficit of 1.70 percent of taxable payroll. The baseline death-rate assumption under alternative II–B is 35 percent.

TABLE 16.—ESTIMATED OASDI AVERAGE INCOME RATES, COST RATES, AND BALANCES, BASED ON ALTERNATIVE II–B WITH VARIOUS DEATH-RATE ASSUMPTIONS

[As a percentage of taxable payroll]

Calendar years	Reduction in death rates [1]		
	18 percent	35 percent	50 percent
Average income rate:			
25-year: 1990–2014	12.99	12.99	13.00
50-year: 1990–2039	12.99	13.01	13.03
75-year: 1990–2064	13.01	13.04	13.08
Average cost rate:			
25-year: 1990–2014	10.66	10.83	11.00
50-year: 1990–2039	12.40	12.83	13.29
75-year: 1990–2064	13.26	13.95	14.78
Balance:			
25-year: 1990–2014	+2.32	+2.17	+2.00
50-year: 1990–2039	+.58	+.17	−.27
75-year: 1990–2064	−.25	−.91	−1.70

---

[1] The measure of the reduction in death rates is the decrease in the age-sex-adjusted death rate during 1990–2064.

Source: 1990 Trustees' Report.

APPENDIX A. STATISTICAL HISTORY AND FUTURE BENEFIT PROJECTIONS OF THE SOCIAL SECURITY PROGRAMS

The Social Security Act of 1935 was signed into law on August 14, 1935. The immediate origin of this legislation was the Committee on Economic Security which had been charged by President Roosevelt with the task of devising safeguards "against misfortune which cannot be wholly eliminated in the man-made world of ours."

In addition to the Federal old-age retirement program (title II), the original Social Security Act also included grants-in-aid to States for: old-age pensions based on need (title I); unemployment compensation systems (title III); aid to dependent children (title IV); maternal and child welfare services, care of crippled children (title V); and public health work (title VI).

The original act has been amended on numerous occasions since 1935. However, the most significant changes to title II were made by the Social Security Amendments of 1939, 1950, 1954, 1956, 1965, 1972, 1977, and 1983. In addition, the Medicare (title XVIII) program was added to the Social Security Act in 1965.

Today the term "Social Security" is seldom used to refer to all of the programs included in the Social Security Act. The term is most often used to refer to either solely title II, the old-age and survivor program insurance program and, since 1956, the disability insurance program, or to both title II and to title XVIII, the Medicare program. This appendix presents historical data concerning the coverage, benefits and financing of each of the three programs.

COVERAGE

The original Social Security Act provided coverage on a mandatory basis under the old-age insurance program of all employees in commerce and industry (except railroad) under age 65. Specifically excluded from coverage "due to difficulties in collecting the tax" were the following services: agricultural labor; domestic services in a private home; casual labor not in the course of the employer's trade or business; and services performed by an officer or member of a crew on a documented vessel. Also specifically excluded were services performed in the employ of: the United States Government, a State or any political subdivision of a State; and nonprofit (including religious) organizations.

Coverage has been extended both on a mandatory and a voluntary basis. Mandatory coverage was extended to workers age 65 and over not otherwise excluded in 1939. In 1950 non-farm self-employed, regularly employed farm and domestic workers, and Federal civilian employees not under a retirement system were covered on a mandatory basis. In addition, the 1950 amendments provided elective coverage to State and local government employees not under a retirement system and employees of nonprofit organizations.

The most significant extensions of coverage provided by the 1954 amendments were to self-employed farmers on a mandatory basis and, on an elective basis, State and local government employees (except firemen and policemen) under retirement systems and ministers. Coverage was extended to members of the uniformed services in 1956, and to ministers and members of religious orders who do not choose to be exempt on religious grounds. In 1983, coverage was extended on a compulsory basis to the following major groups: Federal employees hired after December 31, 1983; current and future Members of Congress; the President and Vice President; Federal judges; and all employees of nonprofit organizations.

Effective in 1983, Federal civilians are covered under the Hospital Insurance portion of the Medicare program. Medicare coverage was also extended on a mandatory basis to State and local government employees hired on or after April 1, 1986. States are permitted to extend Medicare coverage (without extending coverage under Social Security cash benefits) to employees hired prior to April 1986 by voluntary agreement with the Secretary. Effective July 1991, State and local employees not participating in a public retirement system are covered under OASDHI.

The following two tables detail the extension of coverage under the Social Security program in terms of both jobs and wages:

TABLE 1.—CIVILIAN WORKERS COVERED BY SOCIAL SECURITY SYSTEM, 1939–89

[In millions]

Year	Paid civilian employees [1]	OASDI coverage	Percent covered	OASDHI coverage	Percent covered
1939 [2]	43.6	24.0	55.1	24.0	55.1
1944 [2]	51.2	30.8	60.2	30.8	60.2
1949 [2]	56.7	34.3	60.5	34.3	60.5
1955	62.8	51.8	82.5	51.8	82.5
1960	64.6	55.7	86.2	55.7	86.2
1961	65.3	56.1	85.9	56.1	85.9
1962	66.4	57.3	86.3	57.3	86.3
1963	67.6	58.5	86.5	58.5	86.5
1964	69.3	60.1	86.7	60.1	86.7
1965	71.6	62.7	87.6	62.7	87.6
1966	73.6	64.9	88.2	64.9	88.2
1967	74.4	65.7	88.3	65.7	88.3
1968	75.9	67.1	88.4	67.1	88.4
1969	78.0	68.6	87.9	68.6	87.9
1970	77.8	69.9	89.9	69.9	89.9
1971	79.6	71.7	90.1	71.7	90.1
1972	82.6	74.7	90.4	74.7	90.4
1973	85.6	77.6	90.6	77.6	90.6
1974	85.4	77.3	90.5	77.3	90.5
1975	86.0	77.9	90.6	77.9	90.6
1976	89.2	81.0	90.9	81.0	90.9
1977	93.5	85.1	91.0	85.1	91.0
1978	97.0	88.4	91.2	88.4	91.2
1979	99.4	90.7	91.3	90.7	91.3
1980	99.2	90.4	91.1	90.4	91.1
1981	99.0	90.2	91.1	90.2	91.1
1982	98.3	89.8	91.4	89.8	91.4
1983	102.2	93.6	91.6	96.0	94.0
1984	105.5	97.9	92.7	100.3	95.0
1985	107.7	100.0	92.9	102.4	95.1
1986	110.2	102.9	93.3	105.5	95.7
1987	113.3	106.1	93.6	109.3	96.5
1988	115.6	108.4	93.8	112.0	96.8
1989	117.4	110.1	93.8	114.0	97.1

[1] Includes paid employees and self-employed for all years.

[2] Monthly average for these years; all other years as of December.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 2.—CIVILIAN WAGES COVERED BY OASDI SYSTEM, 1946–89 [1]

[Dollars in billions]

Year	Total earnings	Earnings in covered employment		Total earnings in covered employment	Percent of total earnings	Taxable earnings	Percent of earnings in covered employment
		Employed	Self-employed				
1946	$148.3	$79.3	....	$79.3	53.5	$69.1	87.1
1950	186.1	109.8	....	109.8	59.0	87.5	79.7
1955	257.4	171.6	24.5	196.1	76.2	157.5	80.3
1960	324.9	236.0	29.2	265.2	81.6	207.0	78.1
1961	334.8	240.7	30.0	270.7	80.9	209.6	77.4
1962	355.9	257.7	31.3	289.0	81.2	219.1	75.8
1963	372.4	270.6	31.7	302.3	81.2	225.6	74.6
1964	398.2	290.9	33.6	324.5	81.5	236.4	72.8
1965	428.8	311.4	40.3	351.7	82.0	250.7	71.3
1966	469.8	346.7	44.0	390.7	83.2	312.5	80.0
1967	500.1	377.5	44.8	422.3	84.4	330.0	78.1
1968	547.4	413.6	46.4	460.0	84.0	375.8	81.7
1969	597.6	455.7	47.1	502.8	84.1	402.6	80.1
1970	631.7	483.6	48.0	531.6	85.2	415.6	78.2
1971	671.2	509.0	50.7	559.7	83.4	427.0	76.3
1972	737.0	563.3	54.6	617.9	83.8	484.1	78.3
1973	827.7	624.4	62.3	686.7	83.0	561.9	81.8
1974	891.0	681.6	65.2	746.7	83.8	636.8	85.3
1975	940.1	717.2	70.4	787.6	83.8	664.7	84.4
1976	1,037.2	797.2	76.8	874.7	84.3	737.7	84.3
1977	1,146.9	883.1	80.7	963.8	84.0	816.0	84.7
1978	1,295.8	1,002.2	93.7	1,095.9	84.6	917.8	83.7
1979	1,443.9	1,125.0	100.2	1,225.2	84.9	1,073.9	87.7
1980	1,552.6	1,230.5	97.7	1,328.2	85.5	1,175.8	88.5
1981	1,697.1	1,348.2	98.9	1,447.1	85.3	1,293.0	89.4
1982	1,761.6	1,418.2	98.6	1,516.8	86.1	1,364.6	90.0
1983	1,867.0	1,502.0	109.3	1,611.3	86.3	1,454.1	90.2
1984	2,073.4	1,671.5	117.2	1,788.7	86.3	1,608.2	89.9
1985 [2]	2,231.0	1,799.6	130.0	1,929.6	86.5	1,726.1	89.5
1986 [2]	2,376.7	1,919.5	139.0	2,058.5	86.6	1,844.9	89.6
1987 [2]	2,573.1	2,053.6	159.4	2,213.0	86.0	1,961.3	88.6
1988 [2]	2,785.3	2,228.8	182.4	2,411.2	86.6	2,100.9	87.1
1989 [2]	2,952.5	2,381.1	196.0	2,577.1	87.3	2,268.3	88.0

---

[1] Sum of wages and salaries and proprietors' income with inventory valuation and capital consumption adjustments, as estimated by the Bureau of Economic Analysis in the National Income and Product Accounts.

[2] Preliminary.

Source: Social Security Bulletin, Annual Statistical Supplement, 1983, and Office of Research and Statistics, Social Security Administration.

TABLE 3.—NUMBER OF WORKERS AND AVERAGE EARNINGS UNDER OASDI, 1937–1989

Year	Workers with taxable earnings [1]	With maximum earnings	Average earnings per worker	
			Total earnings [2]	Reported taxable
1937	32,900	1,031	$979	$900
1940	35,390	1,196	1,009	932
1945	46,390	6,361	1,543	1,357
1950	48,280	13,936	2,274	1,812
1955	65,200	16,704	3,008	2,416
1960	72,530	20,310	3,656	2,854
1965	80,680	29,136	4,359	3,108
1966	84,600	20,498	4,618	3,694
1967	87,040	22,948	4,852	3,791
1968	89,380	19,120	5,147	4,205
1969	92,060	22,577	5,462	4,373
1970	93,090	24,224	5,711	4,464
1971	93,340	26,404	5,996	4,574
1972	96,240	24,074	6,420	5,030
1973	99,830	20,250	6,879	5,628
1974	101,330	15,310	7,369	6,284
1975	100,200	15,070	7,860	6,633
1976	102,600	15,330	8,525	7,190
1977	105,800	15,700	9,075	7,718
1978	110,600	17,050	9,823	8,278
1979	112,700	11,236	10,805	9,465
1980	113,000	9,903	11,742	10,396
1981	113,000	8,594	12,806	11,442
1982	111,800	7,929	13,629	12,123
1983	112,100	7,044	14,343	12,915
1984	116,300	7,421	15,380	13,828
1985 [3]	120,100	7,778	16,067	14,347
1986 [3]	123,000	7,650	16,736	14,983
1987 [3]	125,600	7,675	17,619	15,616
1988 [4]	129,600	([5])	18,605	16,189
1989 [6]	131,900	([5])	19,857	17,165

---

[1] Relates to wage and salary workers for 1937–50. Beginning 1951, includes self-employment.

[2] Total wages, including estimated amounts above taxable limit, for 1937–50. Beginning 1951, also includes reported total net earnings of self-employed persons.

[3] Data subject to adjustment.

[4] Taxable earnings are preliminary estimates based on Social Security data; employment and total covered earnings are preliminary estimates based on data from Bureau of Labor Statistics and the National Income and Product Accounts.

[5] Data not available.

[6] Preliminary estimates based on data from Bureau of Labor Statistics and the National Income and Product Accounts.

Source: Social Security Bulletin, Annual Statistical Supplement, 1990, Table 4.B1.

BENEFITS

In order to be fully insured under the 1939 Amendments, a worker needed 2 quarters of coverage for each year elapsed since 1936 and before the quarter in which the worker died or turned 65. The minimum required for insured status was 6 quarters and the maximum was 40. The Social Security Amendments of 1950 significantly increased the number of workers who were insured for monthly benefits by requiring two quarters of coverage, which could be earned at any time, for each calendar year after 1950 or age 21, subject to the same maximum and minimum. The 1961 Amendments changed the requirement for fully insured status to only one quarter of coverage for each calendar year after 1950 or age 21. To be insured for disability benefits, under the 1956 amendments, a worker needed to have earned 6 quarters of coverage in the 13 quarters preceding disability (currently insured) and have earned 20 quarters of coverage in the 40 quarters preceding disability, in addition to being fully insured. The 1958 Amendments eliminated the currently insured status requirement. The 1967 Amendments liberalized the insured status requirement for disabled workers under age 31, which significantly increased the number of workers insured for disability beginning in 1969.

The 1935 Social Security Act provided monthly benefits to retired workers age 65 and over and a lump-sum death benefit to the estate of these workers. The monthly benefits were to first be paid beginning January 1, 1942. The 1939 Social Security Amendments provided benefits to dependents—wives aged 65 and over and children under age 16 (changed to 18 in 1946)—of retired workers, and to survivors—widows aged 65, mothers with eligible child in care, children under age 16, and dependent parents—of deceased workers. In addition the 1939 Amendments provided that these benefits first be paid in 1940.

Benefits that have been added in retirement and survivors programs since 1939 include: retired women aged 62–64 (1956); retired men aged 62–64 (1961); widows aged 60–64 (1956 and 1965); widowers aged 60 and over (1950, 1961, and 1972); and, disabled widows age 50 and over (1967).

In 1956, benefits were extended to disabled workers aged 50–64 and to disabled children of retired, disabled, or deceased workers age 18 and over, if they became disabled prior to age 18. The 1958 Amendments provided benefits to dependents of disabled workers on the same basis as dependents of retired workers. Benefits for disabled workers under age 50 were provided in 1960.

Monthly cash benefits have been increased on an ad hoc basis 10 times prior to the first automatic cost-of-living adjustment which was incorporated in the act by the Social Security Amendments of 1972. Beginning with the 1975 increase, benefits have been automatically adjusted to keep pace with inflation. Since 1975, there have been increases annually except during calendar year 1983.

The following tables provide historical background concerning changes in insured status, benefit types, average amounts and increases, and OASDHI benefits paid:

TABLE 4.—ESTIMATED NUMBER OF PERSONS INSURED FOR OASDI, 1940–91 [1]

[In millions]

At beginning of year	Fully insured for retirement and/or survivor benefits			Workers insured in event of disability
	Total	Permanently	Not permanently	
1940	22.9	0.6	22.3	....
1945	31.9	2.8	29.1	....
1950	40.1	14.9	25.2	....
1955	70.2	29.9	40.4	31.9
1960	76.7	42.2	34.6	46.4
1965	92.8	58.3	34.5	53.3
1966	94.8	60.2	34.6	55.0
1967	97.2	61.9	35.3	55.7
1968	99.9	63.3	36.6	56.9
1969	102.6	64.5	38.1	70.1
1970	105.0	65.7	39.4	72.4
1971	108.1	67.1	40.9	74.5
1972	110.6	68.3	42.3	76.1
1973	113.4	69.7	43.6	77.8
1974	116.5	71.0	45.5	80.4
1975	120.0	72.5	47.5	83.3
1976	122.9	74.1	48.8	85.3
1977	125.9	76.0	49.9	87.0
1978	128.9	78.0	50.9	89.3
1979	133.3	80.3	52.9	93.7
1980	137.0	82.6	54.4	98.0
1981	140.0	84.9	55.1	100.5
1982	142.4	87.6	54.9	102.4
1983	144.5	90.5	54.0	104.0
1984	146.0	93.6	52.4	105.0
1985	148.2	96.8	51.3	106.7
1986	150.7	99.9	50.8	109.3
1987	153.0	103.1	49.9	111.5
1988	155.2	107.0	48.2	113.9
1989	157.6	110.8	46.8	115.9
1990	160.1	114.7	45.4	117.8
1991	162.4	118.4	44.0	119.8

---

[1] Estimated counts include those who have sufficient quarters of coverage to meet the eligibility requirements for retired-worker or disabled-worker benefits (including persons already receiving such benefits) or to permit the worker's spouse and children or survivors to establish eligibility for spouse's and children's or survivor's benefits in the event of his or her disability, retirement, or death. Beginning in 1966, transitionally insured persons are included with the permanently insured.

Source: Social Security Bulletin, Annual Statistical Supplement, 1990, Table 4.C1.

TABLE 5.—PERCENT OF INSURED WORKERS AGED 62 AND OVER IN CURRENT PAYMENT STATUS, 1941–91 [1]

	Aged 62–64			Aged 65 and over		
	Male	Female	Total	Male	Female	Total
1941				20	25	20
1945				29	40	30
1950				59	61	59
1955				70	75	71
1956				75	80	76
1960		44	44	84	87	85
1965	32	47	38	89	89	89
1966	32	46	37	90	89	89
1967	33	46	38	90	91	91
1968	33	46	38	90	91	90
1969	34	46	39	90	91	90
1970	34	46	39	90	90	90
1971	36	47	41	90	90	90
1972	39	49	43	91	89	90
1973	41	52	46	92	90	91
1974	44	54	48	94	91	93
1975	46	56	50	93	93	93
1976	49	57	53	94	93	93
1977	49	57	53	95	93	94
1978	52	59	55	95	93	94
1979	51	59	54	95	93	94
1980	52	59	55	95	93	94
1981	53	59	55	95	93	94
1982	54	59	56	95	93	94
1983	57	59	58	96	89	93
1984	57	59	58	97	90	93
1985	57	59	58	96	89	92
1986	58	59	58	96	89	92
1987	59	59	59	96	89	92
1988	59	59	59	96	89	92
1989	59	59	59	96	89	92

---

[1] Includes both OASI and DI worker benefits.

Source: Social Security Bulletin, Annual Statistical Supplement, 1990, Table 4.C4.

TABLE 6.—NUMBER OF OASDI BENEFIT RECIPIENTS WITH BENEFITS IN CURRENT-PAYMENT STATUS, BY BENEFICIARY TYPE, DECEMBER 1940–89

[In thousands]

At end of selected year	Paid from OASI Trust Fund								Paid from DI Trust Fund			
	Total	Retired workers	Wives and husbands	Children [1]	Widowed mothers and fathers	Widows and widowers	Parents [2]	Persons with special age–72 benefits [3]	Total	Disabled workers	Wives and husbands	Children
1940	222	112	30	55	20	4	1	....	....	....	....	....
1945	1,288	518	159	390	121	94	6	....	....	....	....	....
1950	3,477	1,771	508	700	169	314	15	....	....	....	....	....
1955	7,961	4,474	1,192	1,276	292	701	25	....	....	....	....	....
1960	14,157	8,061	2,269	1,845	401	1,544	36	....	687	455	77	155
1961	15,468	8,925	2,392	1,989	428	1,697	37	....	1,027	618	118	291
1962	16,778	9,739	2,531	2,160	452	1,859	37	....	1,275	741	147	387
1963	17,583	10,263	2,581	2,230	462	2,011	37	....	1,452	827	168	457
1964	18,236	10,669	2,604	2,298	471	2,159	36	....	1,563	894	179	490
1965	19,128	11,101	2,614	2,535	472	2,371	35	....	1,739	988	193	558
1966	20,797	11,658	2,640	2,739	488	2,602	35	634	1,970	1,097	220	654
1967	21,565	12,019	2,645	2,873	496	2,770	33	729	2,140	1,193	235	713
1968	22,225	12,421	2,645	3,009	505	2,938	32	676	2,335	1,295	253	787
1969	22,827	12,822	2,644	3,123	512	3,092	30	603	2,488	1,394	264	829
1970	23,564	13,349	2,668	3,234	523	3,227	29	534	2,665	1,493	283	889
1971	24,362	13,927	2,698	3,336	535	3,366	27	472	2,930	1,648	312	971
1972	25,205	14,555	2,735	3,427	541	3,510	26	410	3,271	1,833	350	1,088
1973	26,310	15,365	2,808	3,526	572	3,656	25	358	3,559	2,017	381	1,161

TABLE 6.—NUMBER OF OASDI BENEFIT RECIPIENTS WITH BENEFITS IN CURRENT-PAYMENT STATUS, BY BENEFICIARY TYPE, DECEMBER 1940–89

[In thousands]

At end of selected year	Paid from OASI Trust Fund								Paid from DI Trust Fund			
	Total	Retired workers	Wives and husbands	Children [1]	Widowed mothers and fathers	Widows and widowers	Parents [2]	Persons with special age–72 benefits [3]	Total	Disabled workers	Wives and husbands	Children
1974	26,941	15,959	2,826	3,513	574	3,770	23	278	3,911	2,237	412	1,263
1975	27,732	16,588	2,867	3,562	582	3,889	21	223	4,352	2,489	453	1,411
1976	28,397	17,164	2,896	3,556	579	3,994	20	188	4,624	2,670	474	1,480
1977	29,217	17,821	2,961	3,552	583	4,119	18	159	4,860	2,837	495	1,525
1978	29,718	18,358	2,980	3,441	576	4,212	17	134	4,868	2,880	492	1,497
1979	30,347	18,970	2,991	3,363	574	4,321	16	112	4,777	2,871	475	1,431
1980	30,907	19,562	3,016	3,249	562	4,411	15	93	4,678	2,859	462	1,358
1981	31,550	20,195	3,031	3,178	548	4,508	14	76	4,456	2,777	428	1,252
1982	31,866	20,763	3,039	2,879	515	4,595	12	63	3,973	2,604	366	1,004
1983	32,272	21,419	3,039	2,657	400	4,694	11	51	3,813	2,569	308	936
1984	32,657	21,906	3,051	2,487	382	4,779	10	40	3,822	2,597	304	921
1985	33,151	22,432	3,069	2,374	372	4,863	10	32	3,907	2,657	306	945
1986	33,707	22,981	3,086	2,328	351	4,928	9	25	3,996	2,728	301	967
1987	34,145	23,440	3,090	2,276	329	4,984	8	19	4,045	2,786	291	968
1988	34,553	23,858	3,086	2,241	318	5,029	7	14	4,074	2,830	281	963
1989	35,023	24,327	3,093	2,203	312	5,071	6	10	4,129	2,895	271	962

---

[1] Dependents or survivors. [2] Survivors.

[3] Most payments financed from general revenues.

Source: Social Security Bulletin, Annual Statistical Supplement, 1990, tables 5.A4, 5.F1, and 5.F4.

TABLE 7.—OASDI BENEFICIARY FAMILIES WITH BENEFITS IN CURRENT-PAY STATUS, BY SELECTED FAMILY GROUPS, SELECTED YEARS, 1944–89

[In thousands]

Year [1]	Retired-worker families				Survivor families				Disabled-worker families					
	Worker only			Worker and wife	Aged widow only	Widowed mother and—			Worker only			Worker, wife, and—		Worker and spouse
	Total	Men	Women			1 child	2 children	3 or more children	Total	Men	Women	1 child	2 or more children	
1944	315	253	62	135	69	67	36	20						
1950	1,240	939	301	498	314	82	53	33						
1955	3,266	2,054	1,212	1,124	700	126	86	80						
1960	5,742	2,922	2,820	2,122	1,527	172	113	114	357	261	96	22	32	22
1965	8,386	4,137	4,249	2,400	2,332	182	135	153	714	481	232	54	109	30
1970	10,533	4,904	5,629	2,457	3,080	183	155	182	1,054	680	374	77	164	43
1975	13,520	6,134	7,385	2,618	3,606	221	182	176	1,750	1,080	671	137	250	66
1980	16,314	7,286	9,028	2,736	4,033	239	184	134	2,061	1,257	804	154	228	80
1982	17,519	7,852	9,667	2,784	4,191	236	165	106	1,969	1,208	760	124	163	78
1983	18,162	8,166	9,996	2,830	4,271	161	141	92	1,961	1,215	746	85	143	80
1984	18,613	8,362	10,251	2,839	4,520	159	135	79	1,993	1,241	752	83	140	76
1985	19,132	8,601	10,531	2,861	4,606	158	131	74	2,039	1,267	772	84	140	76
1986	19,664	8,849	10,816	2,883	4,666	151	123	68	2,096	1,301	795	82	136	74
1987	20,137	9,064	11,074	2,893	4,709	141	115	62	2,154	1,338	816	79	132	74
1988	20,567	9,264	11,302	2,896	4,749	137	112	61	2,194	1,353	841	77	125	71
1989	21,036	9,495	11,541	2,903	4,788	137	109	58	2,262	1,390	872	75	120	67

[1] Data for 1981 are not available.

Source: Social Security Bulletin, Annual Statistical Supplement, 1990, Table 5.H1.

TABLE 8.—OASDI AVERAGE MONTHLY BENEFITS IN CURRENT-PAYMENT STATUS, BY SELECTED FAMILY GROUPS, SELECTED YEARS, 1944–89

[Average monthly amount]

At end of year [1]	Retired-worker families				Survivor families				Disabled-worker families					
	Worker only			Worker and wife	Aged widow only	Widowed mother and—			Worker only			Worker, wife, and—		Worker and spouse
	Total	Men	Women			1 child	2 children	3 or more children	Total	Men	Women	1 child	2 or more children	
1944	$23.00	$24.10	$19.30	$37.90	$20.20	$34.40	$47.30	$50.10						
1950	42.20	44.60	34.80	71.70	36.50	76.90	93.90	92.40						
1955	59.10	64.60	49.80	103.50	48.70	106.80	135.40	133.20						
1960	69.90	79.90	59.60	123.90	57.70	131.70	188.00	181.70	$87.90	$91.90	$76.90	$184.70	$192.20	$135.50
1965	80.10	90.50	70.00	141.50	73.90	153.00	219.80	218.10	95.40	100.70	85.00	201.00	216.30	145.90
1970	114.20	128.70	101.60	198.90	102.40	213.00	291.10	289.90	128.10	136.30	113.10	264.10	273.20	199.20
1975	201.60	225.50	181.80	343.90	195.90	367.20	468.60	461.80	218.90	240.00	185.00	441.00	454.00	344.00
1980	333.00	377.10	297.40	566.60	311.60	612.80	759.20	740.50	355.40	396.20	291.70	727.00	746.10	573.00
1982	408.90	465.50	362.90	702.50	379.00	735.60	885.50	867.90	424.20	474.20	344.70	847.40	858.20	690.70
1983	429.70	490.00	380.40	742.90	400.60	774.80	923.00	884.50	439.40	490.40	355.40	867.90	881.80	716.20
1984	448.20	511.60	396.40	781.20	416.30	805.30	948.30	906.60	454.00	507.60	365.70	881.50	885.50	740.40
1985	465.80	531.80	412.00	813.90	434.30	829.60	981.50	924.90	466.90	523.10	374.60	898.10	895.20	765.00
1986	475.20	542.60	420.10	831.30	444.90	841.70	994.00	939.80	470.70	527.80	377.40	896.90	888.30	773.30
1987	499.20	570.40	440.80	873.30	468.70	882.10	1,032.30	968.90	491.60	552.00	392.60	929.40	918.30	815.50
1988	522.70	597.20	461.70	914.10	493.60	921.80	1,070.40	1,012.90	512.20	576.10	409.50	960.20	938.40	855.40
1989	552.10	630.70	487.40	965.60	522.80	967.80	1,120.00	1,064.60	539.30	607.10	431.20	1,009.40	971.90	903.70

---

[1] Data for 1981 not available.

Source: Social Security Bulletin, Annual Statistical Supplement, 1989, Table 5.H1.

TABLE 9.—TOTAL OASDI BENEFITS PAID, AND AS A PERCENT OF PERSONAL INCOME

[In millions]

Year	Total cash benefits	Cash benefits		Personal income [1]	Total (cash) benefits as a percent of personal income
		OASI	DI		
1937	$1	$1		$73,400	(²)
1940	35	35		77,600	(²)
1945	274	274		170,000	.1
1950	961	961		228,100	.3
1955	4,968	4,968		314,200	1.2
1960	11,245	10,677	568	409,400	2.2
1961	12,749	11,862	887	426,000	2.4
1962	14,461	13,356	1,105	453,200	2.5
1963	15,427	14,217	1,210	476,300	2.5
1964	16,223	14,914	1,309	510,200	2.5
1965	18,311	16,737	1,573	552,000	2.6
1966	20,048	18,267	1,781	600,800	2.6
1967	21,407	19,468	1,939	644,500	2.6
1968	24,936	22,642	2,294	707,200	2.8
1969	26,751	24,209	2,542	772,900	2.8
1970	31,863	28,796	3,067	831,800	3.1
1971	37,171	33,413	3,758	894,000	3.4
1972	41,595	37,122	4,473	981,600	3.4
1973	51,459	45,741	5,718	1,101,700	3.8
1974	58,521	51,618	6,903	1,210,100	4.0
1975	66,923	58,509	8,414	1,313,400	4.2
1976	75,665	65,699	9,966	1,451,400	4.2
1977	84,576	73,113	11,463	1,607,500	4.2
1978	92,865	80,352	12,513	1,812,400	4.1
1979	104,264	90,556	13,708	2,034,000	4.2
1980	120,511	105,074	15,437	2,258,500	4.4
1981	140,994	123,795	17,199	2,520,900	4.6
1982	156,138	138,800	17,338	2,670,800	4.9
1983 [3]	167,032	149,502	17,530	2,836,400	4.9
1984 [3]	175,762	157,862	17,900	3,111,900	4.7
1985 [3]	186,196	167,360	18,836	3,314,500	4.6
1986 [3]	196,692	176,845	19,847	3,534,300	4.6
1987 [3]	204,156	183,644	20,512	3,777,600	4.5
1988 [3]	217,214	195,522	21,692	4,064,500	4.5
1989 [3]	230,850	207,977	22,873	4,427,900	4.4

[1] Data from "Survey of Current Business," table 2.1.

[2] Less than 0.05 percent.

[3] Unnegotiated checks not deducted.

Source: Social Security Bulletin, Annual Statistical Supplement, 1990, table 4.A4.

TABLE 10.—ESTIMATED COST OF OASDI AND HI SYSTEMS AS PERCENT OF GNP UNDER ALTERNATIVE II–B, 1990–2064

[In percent]

Calendar year	OASDI	HI	OASDI and HI [1]
Alternative II–B:			
1990	4.56	1.15	5.72
1991	4.57	1.20	5.78
1992	4.57	1.24	5.82
1993	4.58	1.29	5.87
1994	4.56	1.34	5.91
1995	4.54	1.38	5.94
1996	4.52	1.44	5.95
1997	4.49	1.48	5.97
1998	4.47	1.53	6.00
1999	4.45	1.57	6.03
2000	4.45	1.62	6.08
2005	4.45	1.80	6.25
2010	4.61	2.04	6.65
2015	5.06	2.36	7.42
2020	5.67	2.64	8.31
2025	6.21	2.96	9.17
2030	6.54	3.22	9.76
2035	6.61	3.37	9.98
2040	6.52	3.42	9.94
2045	6.44	3.43	9.87
2050	6.45	3.44	9.89
2055	6.51	3.45	9.95
2060	6.53	3.46	10.00
Summarized rates:			
25-year: 1990–2014	4.57	1.69	6.25
50-year: 1990–2039	5.31	2.30	7.60
75-year: 1990–2064	5.66	2.63	8.29

Source: 1990 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Table G1.

TABLE 11.—COST RATES FOR THE OASI AND DI TRUST FUNDS AS A PERCENT OF TAXABLE PAYROLL, 1970–90

[In percent]

Calendar year	OAI [1]	SI [1]	OASI	DI	OASDI
1970	5.36	1.96	7.32	.81	8.12
1971	6.07	2.20	8.27	.97	9.23
1972	5.98	2.15	8.13	1.01	9.14
1973	6.21	2.38	8.59	1.09	9.69
1974	6.20	2.35	8.55	1.16	9.70
1975	6.77	2.52	9.29	1.36	10.65
1976	6.89	2.53	9.42	1.44	10.86
1977	6.93	2.53	9.46	1.50	10.97
1978	6.85	2.44	9.29	1.45	10.74
1979	6.57	2.31	8.88	1.35	10.23
1980	6.95	2.41	9.36	1.38	10.74
1981	7.45	2.52	9.97	1.39	11.36
1982	8.01	2.58	10.59	1.34	11.94
1983	7.84	2.43	10.27	1.22	11.50
1984	7.73	2.35	10.08	1.16	11.24
1985 [2]	7.64	2.31	9.96	1.13	11.09
1986 [2]	7.57	2.28	9.84	1.12	10.96
1987 [2]	7.38	2.21	9.58	1.09	10.68
1988 [2]	7.34	2.19	9.54	1.07	10.61
1989 [2]	7.26	2.16	9.42	1.05	10.47
1990 [2]	7.36	2.18	9.54	1.06	10.60

[1] These estimates are based on the assumption that total OASI expenditures are distributed between OAI and SI in the same proportions as benefit payments.

[2] Preliminary.

Note: All numbers in this table are based on figures published in 1990 and earlier Trustees Reports.

Source: Office of the Actuary, Social Security Administration.

TABLE 12.—PAST AND FUTURE EARNINGS LEVELS, PRIMARY INSURANCE AMOUNTS IN ACTUAL AND CONSTANT DOLLARS, AND REPLACEMENT RATES, UNDER PRESENT LAW, 1953–2040 [1]

Year	Actual earnings in previous year			Sum of monthly PIA's for year of entitlement [2]						Replacement rates [3] (in percent)		
				Actual dollars			1990 constant dollars					
	Low earner [4]	Average earner	Maximum earner [4]	Low earner	Average earner	Maximum earner	Low earner	Average earner	Maximum earner	Low earner	Average earner	Maximum earner
1953 [5]	1,338	2,973	3,600	674	912	1,020	3,209	4,340	4,854	50.4	30.7	28.3
1955 [5]	1,420	3,156	3,600	745	1,091	1,182	3,546	5,191	5,625	52.5	34.6	32.8
1960 [5]	1,735	3,856	4,800	852	1,284	1,428	3,660	5,515	6,134	49.1	33.3	29.8
1965 [5]	2,059	4,576	4,800	938	1,439	1,580	3,789	5,810	6,382	45.6	31.4	32.9
1970 [5]	2,652	5,894	7,800	1,286	2,021	2,278	4,222	6,633	7,476	48.5	34.3	29.2
1975 [5]	3,614	8,031	13,200	[6] 2,166	3,400	3,973	[6] 5,126	8,045	9,401	[6] 59.9	42.3	30.1
1980 [5]	5,166	11,479	22,900	3,520	5,862	7,437	5,435	9,052	11,483	68.1	51.1	32.5
1985	7,261	16,135	37,800	[6] 4,445	6,598	8,629	[6] 5,323	7,900	10,332	[6] 61.2	40.9	22.8
1988	8,292	18,427	43,800	[6] 4,840	7,543	10,097	[6] 5,295	8,253	11,046	[6] 58.4	40.9	23.1
1989	8,700	19,334	45,000	[6] 5,036	8,053	10,837	[6] 5,258	8,408	11,315	[6] 57.9	41.7	24.1
1990	9,045	20,100	48,000	[6] 5,275	8,684	11,253	[6] 5,275	8,684	11,735	[6] 58.3	43.2	24.5
2000	15,228	33,839	81,300	8,522	14,077	20,375	5,675	9,375	13,569	56.0	41.6	25.1
2010	25,522	56,716	136,800	14,164	23,433	36,243	6,372	10,543	16,306	55.5	41.3	26.5
2020	42,776	95,058	229,200	23,744	39,281	62,342	7,217	11,939	18,948	55.5	41.3	27.2
2030	71,694	159,321	383,700	39,525	65,507	103,898	8,116	13,450	21,333	55.1	41.1	27.1
2040	120,162	267,028	642,600	66,249	109,796	174,155	9,190	15,230	24,157	55.1	41.1	27.1

---

[1] For workers becoming entitled at normal retirement age (NRA) with steady career earnings. For years 1953–2000, NRA is 65. For 2010 and 2020, NRA is 66; for 2030 and thereafter, NRA is 67. [2] Sum rounded to nearest dollars. [3] Total of monthly benefits payable for year of entitlement expressed as percent of earnings in year prior to entitlement. [4] Low earner has earnings equal to 45 percent of the average wage as determined by the Social Security Administration; maximum earner has earnings equal to the maximum wages taxable for Social Security purposes. [5] PIA's and replacement rates for these workers are based on the pre-1977 benefit formula. [6] Based on special minimum PIA computation.

Source: Office of the Actuary, Social Security Administration.

TABLE 13.—ILLUSTRATIONS OF CURRENT SOCIAL SECURITY BENEFIT LEVELS FOR PERSONS BORN FROM 1895 TO 1935 AND RETIRING AT 65 [1]

	Actual benefit levels in 1991 (or projected in 1991 dollars)	Benefit levels, if initial benefits had risen at the same rate as wages after 1972 [2]	Difference
Retirement in January of:			
1960	567	567	
1961	572	572	
1962	577	577	
1963	582	582	
1964	588	588	
1965	589	589	
1966	604	604	
1967	609	609	
1968	619	619	
1969	622	622	
1970	640	640	
1971	651	651	
1972	661	661	
1973	672	672	
1974	687	715	−28
1975	702	683	+19
1976	727	679	+48
1977	751	683	+68
1978	782	683	+99
1979	802	692	+110
1980	821	685	+136
1981	850	653	+197
1982	768	647	+121
1983	739	635	+104
1984	700	644	+56
1985	684	659	+25
1986	697	666	+31
1987	709	677	+32
1988	718	691	+27
1989	737	697	+40
1990	758	692	+66
	Projected (in constant 1991 dollars)		
1991	751	692	+59
1992	766	698	+68
1993	768	705	+63
1994	759	712	+47
1995	764	720	+44
1996	772	729	+43
1997	780	739	+41
1998	788	748	+40

TABLE 13.—ILLUSTRATIONS OF CURRENT SOCIAL SECURITY BENEFIT LEVELS FOR PERSONS BORN FROM 1895 TO 1935 AND RETIRING AT 65 [1]—Continued

	Actual benefit levels in 1991 (or projected in 1991 dollars)	Benefit levels, if initial benefits had risen at the same rate as wages after 1972 [2]	Difference
1999	799	757	+42
2000	810	767	+43

---

[1] For full-career worker who always earned the average wage. Future benefit levels based on the updated Intermediate II–B assumptions of the 1990 Trustee's Report.

[2] The benefits for 1966–1991 also reflect COLAs that would have been paid after retirement and through January 1991.

Source: Congressional Research Service (CRS), February 1991.

FINANCING

The payroll tax is imposed on covered earnings up to a specific dollar amount. Workers who earn more than the maximum taxable earnings base do not pay FICA (Federal Insurance Contributions Act) or SECA (Self-Employed Contributions Act) tax on their earnings above the base.

The earnings base has increased numerous times from 1937 through 1991. A majority of these increases have been provided through specific legislative amendments. Currently, the earnings base is automatically adjusted annually according to the increase in average wages in the economy, but only if a cost-of-living benefit increase becomes effective for the previous December. (The Omnibus Reconciliation Act of 1989 raised the wage base beyond the automatic increase by including certain types of "deferred compensation," such as contributions to section 401(k) retirement plans, as income for FICA tax purposes.)

The tax rates have also been changed many times since 1937. Under the original act, the OASI tax rate was scheduled to gradually increase from 1 percent in 1937 to 3 percent in 1949. These increases were delayed several times during the 1940's and the tax rate did not increase to 1.5 percent until 1950. The current 1991 OASI tax rate is 5.60 percent. The tax for the disability insurance program was 0.25 percent in 1957 and is .60 percent in 1991. The hospital insurance (Medicare part A) rate was 0.35 percent in 1966 and is currently 1.45 percent. (For 1984 only, employees were allowed a credit of 0.3 percent of their taxable wages against their FICA tax liability, reducing the effective tax rate to 6.7 percent.)

Beginning in 1984, the OASDHI rates for self-employed persons is equal to the combined employer-employee OASDHI rate. For 1984, self-employed persons were allowed a credit (comparable to the credit allowed employers against the FICA tax) against SECA tax equal to 2.7 percent of net self-employment income. For 1985, the amount of the credit was 2.3 percent. For 1986 through 1989, the credit was 2.0 percent.

Effective in 1990 and thereafter, the credit was replaced with a system designed to achieve parity between employees and the self-employed. Under this system:

1. The base of the self-employment tax is adjusted downward to reflect the fact that employees do not pay FICA tax on the value of the employer's FICA tax.
2. A deduction is allowed for income tax purposes, for half of SECA liability, to allow for the fact that employees do not pay income tax on the value of the employer's FICA tax.

In 1991, a separate earnings base of 125,000 was provided for HI coverage.

The following four tables detail the annual taxable earnings base, the three individual and combined tax rates and the annual maximum contribution for both employees, employers, and self-employed persons.

TABLE 14.—ANNUAL MAXIMUM TAXABLE EARNINGS AND CONTRIBUTION RATE: EMPLOYERS AND EMPLOYEES, 1937–2000 AND THEREAFTER

Beginning—	Annual maximum taxable earnings	Contribution rate			
		Total	OASI	DI	HI
1937	$3,000	1	1		
1950	3,000	1.5	1.5		
1951	3,600	1.5	1.5		
1954	3,600	2	2		
1955	4,200	2	2		
1957	4,200	2.25	2	0.25	
1959	4,800	2.5	2.25	.25	
1960	4,800	3	2.75	.25	
1962	4,800	3.125	2.875	.25	
1963	4,800	3.625	3.375	.25	
1966	6,600	4.2	3.5	.35	0.35
1967	6,600	4.4	3.55	.35	.5
1968	7,800	4.4	3.325	.475	.6
1969	7,800	4.8	3.725	.475	.6
1970	7,800	4.8	3.65	.55	.6
1971	7,800	5.2	4.05	.55	.6
1972	9,000	5.2	4.05	.55	.6
1973	10,800	5.85	4.3	.55	1.0
1974	13,200	5.85	4.375	.575	.9
1975	14,100	5.85	4.375	.575	.9
1976	15,300	5.85	4.375	.575	.9
1977	16,500	5.85	4.375	.575	.9
1978	17,700	6.05	4.275	.775	1.00
1979	22,900	6.13	4.33	.75	1.05
1980	25,900	6.13	4.52	.56	1.05
1981	29,700	6.65	4.70	.65	1.3
1982	32,400	6.7	4.575	.825	1.3
1983	35,700	6.7	4.775	.625	1.3
1984 [1]	37,800	7.0	5.2	.5	1.3
1985	39,600	7.05	5.2	.5	1.35
1986	42,000	7.15	5.2	.5	1.45
1987	43,800	7.15	5.2	.5	1.45
1988	45,000	7.51	5.53	.53	1.45
1989	48,000	7.51	5.53	.53	1.45
1990	[2] 51,300	7.65	5.6	.60	1.45
1991	53,400	7.65	5.6	.6	1.45
1992–1999	([3])	7.65	5.6	.60	1.45
2000 and thereafter	([3])	7.65	5.49	.71	1.45

---

[1] Tax credits apply for 1984.

[2] Automatic increase based on increase in average earnings which, under 1989 Omnibus Budget Reconciliation Act, include certain types of "deferred compensation," such as contributions to section 401(k) retirement plans.

[3] Subject to automatic increase.

Source: Social Security Bulletin, Annual Statistical Supplement, 1989, Table 2.A1.

TABLE 15.—ANNUAL MAXIMUM TAXABLE EARNINGS AND CONTRIBUTION RATE: SELF-EMPLOYED, 1937–2000 AND THEREAFTER

Beginning—	Annual maximum taxable earnings	Contribution rate			
		Total	OASI	DI	HI
1937	$3,000				
1950	3,000				
1951	3,600	2.25	2.25		
1954	3,600	3	3		
1955	4,200	3	3		
1957	4,200	3.375	3	0.375	
1959	4,800	3.75	3.375	.375	
1960	4,800	4.5	4.125	.375	
1962	4,800	4.7	4.325	.375	
1963	4,800	5.4	5.025	.375	
1966	6,600	6.15	5.275	.525	0.35
1967	6,600	6.4	5.375	.525	.5
1968	7,800	6.4	5.0875	.7125	.6
1969	7,800	6.9	5.5875	.7125	.6
1970	7,800	6.9	5.475	.825	.6
1971	7,800	7.5	6.075	.825	.6
1972	9,000	7.5	6.075	.825	.6
1973	10,800	8	6.205	.795	1.0
1974	13,200	7.9	6.185	.815	.9
1975	14,100	7.9	6.185	.815	.9
1976	15,300	7.9	6.185	.815	.9
1977	16,500	7.9	6.185	.815	.9
1978	17,700	8.10	6.01	1.09	1.00
1979	22,900	8.10	6.01	1.04	1.05
1980	25,900	8.10	6.2725	.7775	1.05
1981	29,700	9.30	7.025	.975	1.30
1982	32,400	9.35	6.8125	1.2375	1.30
1983	35,700	9.35	7.1125	.9375	1.30
1984 [1]	37,800	14.0	10.4	1.0	2.6
1985 [1]	39,600	14.1	10.4	1.0	2.7
1986 [1]	42,000	14.3	10.4	1.0	2.9
1987 [1]	43,800	14.3	10.4	1.0	2.9
1988 [1]	45,000	15.02	11.06	1.06	2.9
1989 [1]	48,000	15.02	11.06	1.06	2.9
1990	51,300	15.3	11.2	1.2	2.9
1991	53,400	15.3	11.2	1.2	2.9
1992–1999	(2)	15.3	11.2	1.2	2.9
2000 and thereafter	(2)	15.3	10.98	1.42	2.9

---

[1] Tax credits apply from 1984 through 1989.

[2] Subject to automatic increase.

Source: Social Security Bulletin, Annual Statistical Supplement, 1989, Table 2.A1.

TABLE 16.—MAXIMUM ANNUAL CONTRIBUTION: EMPLOYEE, SELF-EMPLOYED, 1937–91

Beginning—	Employee				Self-employed total
	Total	OASI	DI	HI	
1937	$30.00	$30.00			
1950	45.00	45.00			
1951	54.00	54.00			$81.00
1954	72.00	72.00			108.00
1955	84.00	84.00			126.00
1957	94.50	84.00	$10.50		141.75
1959	120.00	108.00	12.00		180.00
1960	144.00	132.00	12.00		216.00
1962	150.00	138.00	12.00		225.60
1963	174.00	162.00	12.00		259.20
1966	277.20	231.00	23.10	$23.10	405.90
1967	290.40	234.30	23.10	33.00	422.40
1968	343.20	259.35	37.05	46.80	499.20
1969	374.40	290.55	37.05	46.80	538.20
1970	374.40	284.70	42.90	46.80	538.20
1971	405.60	315.90	42.90	46.80	585.00
1972	468.00	364.50	49.50	54.00	675.00
1973	631.80	464.40	59.40	108.00	864.00
1974	772.20	577.50	75.90	118.80	1,042.80
1975	824.85	616.88	81.08	126.90	1,113.90
1976	895.05	669.38	87.98	137.70	1,208.70
1977	965.25	721.88	94.88	148.50	1,303.50
1978	1,070.85	756.68	137.18	177.00	1,433.70
1979	1,403.77	991.57	171.75	240.45	1,854.90
1980	1,587.67	1,170.68	145.04	271.95	2,097.90
1981	1,975.05	1,395.90	193.05	386.10	2,762.10
1982	2,170.80	1,482.30	267.30	421.20	3,029.40
1983	2,391.90	1,704.68	223.12	464.10	3,337.95
1984	[1] 2,532.60	1,862.15	179.05	491.40	[1] 4,271.40
1985	2,791.80	2,059.20	198.00	534.60	[1] 4,672.80
1986	3,003.00	2,184.00	210.00	609.00	[1] 5,166.00
1987	3,131.70	2,277.60	219.00	635.10	[1] 5,387.40
1988	3,379.50	2,488.50	238.50	652.50	[1] 5,859.00
1989	3,604.80	2,654.40	254.40	696.00	[1] 6,249.60
1990	3,924.45	2,872.80	307.80	743.85	7,848.90
1991	5,123.30	2,990.40	320.40	[2] 1,812.50	10,246.60
Total cumulative employee contributions, 1957–91	46,330.54	33,433.17	3,824.42	9,072.95	75,835.15

---

[1] Reflects reduction for tax credit of 0.3 percent of employee's taxable wages in 1984 (allowed for employee's OASDI contribution only) and 2.7 percent in 1984, 2.3 percent in 1985, and 2.0 percent in 1986–89 against self-employment OASDHI taxes. [2] Maximum taxable earnings for HI $125,000.

Source: Social Security Bulletin, Annual Statistical Supplement, 1989, Table 2.A3, and SSA Office of the Actuary.

TABLE 17.—ASSETS OF THE OLD-AGE AND SURVIVORS INSURANCE (OASI), DISABILITY INSURANCE (DI), AND HOSPITAL INSURANCE (HI) TRUST FUNDS

Calendar year	Assets at end of year in billions of dollars			Combined	Assets at beginning of year as a percent of outgo during year	
	OASI	DI	HI		OASI	OASDI
1937	0.77			0.77		
1940	2.03			2.03	2,781	
1945	7.12			7.12	1,975	
1950	13.72			13.72	1,156	
1955	21.66			21.66	405	
1960	20.32	2.29		22.61	180	186
1961	19.73	2.44		22.16	163	169
1962	18.34	2.37		20.71	141	146
1963	18.48	2.24		20.72	123	128
1964	19.13	2.05		21.17	118	122
1965	18.24	1.61		19.84	109	110
1966	20.57	1.74	0.94	23.25	96	95
1967	24.22	2.03	1.07	27.32	101	99
1968	25.70	3.03	2.08	30.81	103	101
1969	30.08	4.10	2.51	36.69	102	103
1970	32.45	5.61	3.20	41.27	101	103
1971	33.79	6.65	3.03	43.47	94	99
1972	35.32	7.46	2.94	45.71	88	93
1973	36.49	7.93	6.47	50.88	75	80
1974	37.78	8.11	9.12	55.01	68	73
1975	36.99	7.35	10.52	54.86	63	66
1976	35.39	5.75	10.61	51.74	54	57
1977	32.49	3.37	10.44	46.30	47	47
1978	27.52	4.23	11.48	43.22	39	37
1979	24.66	5.63	13.23	43.52	30	30
1980	22.82	3.63	13.75	40.20	23	25
1981	21.49	3.05	18.75	43.29	18	18
1982	[1] 22.09	[1] 2.69	[1] 8.16	32.94	[1] 15	[1] 15
1983	[1] 19.67	[1] 5.20	[1] 12.86	37.73	[1] 15	[1] 14
1984	[1] 27.12	[1] 3.96	[1] 15.69	46.77	[1] 20	[1] 21
1985	[1] 35.84	[1] 6.32	[1] 20.50	62.66	[1] 24	[1] 24
1986	[1] 39.08	[1] 7.78	[1] 39.96	86.82	[1] 28	[1] 29
1987	62.15	6.66	53.73	122.54	30	31
1988	102.90	6.86	69.64	179.40	41	41
1989	155.06	7.90	85.56	248.53	59	57
1990 [2]					78	74

[1] In 1982, $17,519 million was lent to the OASI trust fund from the DI and HI trust funds. Repayments were made to the DI and HI trust funds in 1985 and 1986. The values presented here include these transfers.

[2] Preliminary.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987 and 1990 Annual Report of the Board of Trustees.

Administrative Costs

Table 23 displays total OASDI disbursements, benefit payments, and administrative expenses since 1980. Table 23 also shows benefit payments and administrative expenses as a percent of total disbursements.

TABLE 18.—FEDERAL OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE (OASDI) TRUST FUNDS: BENEFIT AND ADMINISTRATIVE COSTS, FISCAL YEAR TO 1980 TO FISCAL YEAR 1991

[Outlays in millions of dollars]

Fiscal year	Total disbursements	Benefit payments	Administrative expenses	Benefit payments as a percent of disbursements	Administrative expenses as a percent of disbursements
1980	$118,548	$115,624	$1,494	97.5	1.3
1981	139,584	136,267	1,703	97.6	1.2
1982	155,963	152,097	2,046	97.5	1.3
1983	170,058	165,569	2,210	97.4	1.3
1984	178,199	173,603	2,170	97.4	1.2
1985	188,504	183,959	2,192	97.6	1.2
1986	198,730	193,869	2,209	97.6	1.1
1987	207,323	202,430	2,279	97.6	1.1
1988	219,290	213,907	2,532	97.5	1.2
1989	232,491	227,150	2,407	97.7	1.0
1990	248,605	243,247	2,275	97.8	0.9
1991 estimated	268,947	262,855	2,477	97.7	0.9

Note: Disbursements include, in addition to benefit payments and administrative costs shown above, the financial interchange with the Railroad Retirement Board and reimbursements for vocational rehabilitation. These other disbursements ranged from $1.6 billion in Fiscal Year 1980 to $3.1 billion in Fiscal Year 1990.

Source: SSA, Office of Budget.

Section 4. Medicare

Medicare, authorized under title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (part A) program and the supplementary medical insurance (part B) program.

ELIGIBILITY

Most Americans age 65 or older are automatically entitled to protection under part A. Persons age 65 or older who are not "fully insured" (i.e., not eligible for monthly Social Security or railroad retirement cash benefits) may obtain coverage, providing they pay the full actuarial cost of such coverage. For those who are not automatically entitled to part A benefits, the monthly premium, as of January 1, 1991, is $177. Also eligible, after a 2-year waiting period, are people under age 65 who are receiving monthly Social Security benefits on the basis of disability and disabled railroad retirement system annuitants. (Dependents of the disabled are not eligible.) Most people who need a kidney transplant or renal dialysis because of chronic kidney disease are, under certain circumstances, entitled to benefits under part A regardless of age.

Part B of Medicare is voluntary. All persons age 65 or older (whether "insured" or not) may elect to enroll in the supplementary medical insurance program by paying the monthly premium. Persons eligible for part A by virtue of disability or chronic kidney disease may also elect to enroll in part B. The premium, as of January 1, 1991, is $29.90 per month.

NUMBER OF BENEFICIARIES

In fiscal year 1991, approximately 30.3 million aged and 3.3 million disabled will have protection under part A. Of those, it is estimated that 6.3 million aged and 0.7 million disabled will actually receive reimbursed services. In fiscal year 1991, 29.8 million aged and 3.0 million disabled will be enrolled in part B. Over 24.0 million of the aged and 2.2 million of the disabled will receive part B reimbursed services.

TABLE 1.—NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES, AND AVERAGE AND TOTAL MEDICARE BENEFIT PAYMENTS

[Persons in thousands]

	Fiscal year—											Projected average annual growth (percent)		
	1975 (actual)	1980 (actual)	1985 (actual)	1986 (actual)	1987 (actual)	1988 (actual)	1989 (actual)	1990 [1] (estimate)	1991 [1] (estimate)	1992 [1] (estimate)	1995 [1] (estimate)	1975–95	1985–90	1990–95
Part A:														
Persons with hospital insurance protection (monthly average):														
Aged	21,795	24,571	27,123	27,728	28,239	28,779	29,366	29,772	30,332	30,880	32,191	2.2	1.9	1.6
Disabled	2,047	2,968	2,944	2,986	3,042	3,115	3,200	3,266	3,339	3,410	3,675	3.7	2.1	2.4
Total	23,842	27,539	30,067	30,714	31,281	31,894	32,566	33,038	33,671	34,290	35,866	2.3	1.9	1.7
Beneficiaries receiving reimbursed services:														
Aged	4,906	5,943	6,168	6,028	6,041	6,020	6,050	6,160	6,330	6,510	7,000	2.3	0.0	2.6
Disabled	456	721	672	667	666	665	675	685	705	725	795	4.0	0.4	3.0
Total	5,362	6,664	6,840	6,695	6,707	6,685	6,725	6,845	7,035	7,235	7,795	2.5	0.0	2.6
Average annual benefit per person enrolled: [2] [3]														
Aged	$326	$853	$1,563	$1,564	$1,570	$1,610	$1,745	$1,979	$2,035	$2,210	$2,829	17.0	4.8	7.4
Disabled	$345	$948	$1,807	$1,843	$1,797	$1,769	$1,896	$2,079	$2,148	$2,332	$2,938	18.0	2.8	7.2
Total	$327	$863	$1,587	$1,591	$1,592	$1,626	$1,760	$1,989	$2,046	$2,222	$2,840	17.1	4.6	7.4

Part B:														
Persons enrolled (average):														
Aged	21,504	24,422	27,049	27,593	28,126	28,647	28,976	29,393	29,777	30,145	31,227	2.3	1.7	1.2
Disabled	1,835	2,698	2,672	2,717	2,772	2,831	2,872	2,915	2,955	2,996	3,168	3.8	1.8	1.7
Total	23,339	27,120	29,721	30,310	30,898	31,478	31,848	32,308	32,732	33,141	34,395	2.4	1.7	1.3
Beneficiaries receiving reimbursed services:														
Aged	11,311	16,034	20,199	21,467	22,353	22,953	23,362	23,794	24,045	24,335	25,708	6.0	3.3	1.6
Disabled	797	1,669	1,933	2,010	2,065	2,123	2,165	2,195	2,218	2,249	2,422	9.3	2.6	2.0
Total	12,108	17,703	22,132	23,477	24,418	25,076	25,527	25,989	26,263	26,584	28,130	6.2	3.3	1.6
Average annual benefit per person enrolled: [2]														
Aged	$153	$347	$705	$800	$937	$1,040	$1,130	$1,252	$1,346	$1,514	$2,185	16.5	12.2	11.8
Disabled	$259	$615	$1,021	$1,141	$1,293	$1,372	$1,435	$1,599	$1,517	$1,655	$2,223	14.7	9.4	6.8
Total	$161	$374	$733	$831	$969	$1,070	$1,158	$1,283	$1,361	$1,526	$2,189	16.3	11.8	11.3

---

[1] Represents current law. Does not include regulations or legislative proposals.

[2] Does not include administrative cost.

[3] Includes Part A catastrophic benefits beginning in fiscal year 1989. There will be no catastrophic benefits after fiscal year 1990.

Source: Health Care Financing Administration, Division of Budget.

TABLE 2.—BENEFIT PAYMENTS BY SERVICE UNDER MEDICARE PART A AND PART B FISCAL YEARS 1975, 1980, 1985, 1990, 1991, 1992 AND 1995

[Dollars in millions]

Fiscal year:	1975		1980 (percent)	1985 (percent)	1990 (est.) [1]		1991 (est.) [1]		1992 (est.) [1]		1995 (est.) [1]		Projected average annual growth (percent)		
	Percent	Amount			Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	1975–85	1985–90	1990–95
Part A:															
For inpatient hospital services	70.5	$9,947	67.4	64.7	54.9	$58,800	54.7	$62,047	54.2	$68,701	52.0	$92,050	90.8	5.5	9.4
For skilled nursing facility services	1.9	273	1.1	0.8	3.0	3,202	2.3	2,631	2.2	2,762	2.0	3,477	76.6	41.2	1.7
For home health services	0.9	133	1.6	3.0	3.2	3,400	3.3	3,754	3.2	4,118	3.0	5,246	116.4	9.9	9.1
For hospice services	0.0	0	0.0	0.0	0.3	320	0.4	465	0.5	605	0.6	1,100	NA	NA	28.0
Total benefit payments	73.3	10,353	70.1	68.6	61.3	65,722	60.7	68,897	60.1	76,186	57.5	101,873	91.1	6.6	9.2
Part B:															
For physician services	21.7	3,067	23.0	24.2	27.0	28,955	26.5	30,076	26.5	33,655	27.0	47,866	94.5	11.5	10.6
For outpatient services	3.8	530	5.4	5.6	7.8	8,368	8.4	9,522	8.7	10,984	9.7	17,238	100.3	16.5	15.6
For other medical and health services	1.2	168	1.4	1.6	3.9	4,127	4.4	4,951	4.7	5,945	5.7	10,174	98.2	29.9	19.8
Total benefit payments	26.7	3,765	29.9	31.4	38.7	1,450	39.3	44,549	39.9	50,584	42.5	75,278	95.6	13.7	12.7
Total	100.0	14,118	100.0	100.0	100.0	107,173	100.0	113,446	100.0	126,770	100.0	177,151	92.4	9.0	10.6

[1] Represents projections of current law.

Source: Health Care Financing Administration, Division of Budget.

TABLE 3.—BENEFIT PAYMENTS BY SERVICE UNDER MEDICARE PART A AND PART B, FISCAL YEARS 1975 THROUGH 1990

[In millions of dollars]

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989 [1]	1990 [1]
Part A																
For inpatient hospital services	9,947	11,742	14,265	16,685	19,072	22,850	27,751	32,720	36,075	39,082	45,009	46,043	46,840	48,787	52,470	56,748
For skilled nursing facility services	273	308	351	353	363	387	428	462	511	536	570	585	623	720	2,193	2,649
For home health service	133	217	289	361	437	539	715	1,161	1,516	1,841	2,116	2,204	2,287	2,261	2,534	2,816
For hospice services	0	0	0	0	0	0	0	0	0	2	15	35	63	90	120	180
Total benefit payments	10,353	12,267	14,905	17,399	19,872	23,776	28,894	34,343	38,102	41,461	47,710	48,867	49,813	51,858	57,317	62,393
Part B																
For physician services	2,874	3,438	4,286	4,953	5,948	7,283	8,860	10,649	12,890	14,581	16,224	18,553	21,926	24,243	26,136	29,986
For radiology and pathology services	193	251	313	373	449	531	654	743	609	615	565	(2)	(2)	(2)	(2)	(2)
For outpatient service	530	745	988	1,230	1,496	1,847	2,248	2,916	3,346	3,534	3,903	4,922	5,780	6,456	7,329	8,747
For other medical and health services	168	238	280	296	366	483	583	498	642	743	1,116	1,694	2,231	2,983	3,388	4,231
Total benefit payments	3,765	4,672	5,867	6,852	8,259	10,144	12,345	14,806	17,487	19,473	21,808	25,169	29,937	33,682	36,853	42,964
Total	14,118	16,939	20,772	24,251	28,131	33,920	41,239	49,149	55,589	60,934	69,518	74,036	79,750	85,540	94,170	105,357

[1] Represents estimates of current law. Does not include regulations or legislative proposals. Includes catastrophic benefits, beginning in FY 1989 and ending in fiscal year 1990.

[2] Not available. Physician services for FY 1986 through FY 1990 include radiology and pathology services.

Source: Health Care Financing Administration, Division of Budget.

TABLE 4.—HISTORICAL AND PROJECTED AMOUNTS OF PART A (HOSPITAL INSURANCE) AND PART B (SMI) DEDUCTIBLE, COINSURANCE AND PREMIUMS [1]

For benefit periods beginning in calendar year	Inpatient hospital [2]			Skilled nursing facility 21st thru 100th day coinsurance per day [5]	HI monthy premium [6]		SMI deductible	SMI premium	
	First 60 days deductible	61st thru 90th day coinsurance per day [3]	60 lifetime reserve days (non-renewable) coinsurance per day [4]		Effective date	Amount		Effective date	Amount
1966	$40	$10	(7)	(7)			$50	7/66	$3.00
1967	40	10	(7)	$5.00			50		3.00
1968	40	10	$20	5.00			50	4/68	4.00
1969	44	11	22	5.50			50		4.00
1970	52	13	26	6.50			50	7/70	5.30
1971	60	15	30	7.50			50	7/71	5.60
1972	68	17	34	8.50			50	7/72	5.80
1973	72	18	36	9.00	7/73	$33	60	[8] 9/73	6.30
1974	84	21	42	10.50	7/74	36	60	7/74	6.70
1975	92	23	46	11.50	7/75	40	60		6.70
1976	104	26	52	13.00	7/76	45	60	7/76	7.20
1977	124	31	62	15.50	7/77	54	60	7/77	7.70
1978	144	36	72	18.00	7/78	63	60	7/78	8.20
1979	160	40	80	20.00	7/79	69	60	7/79	8.70
1980	180	45	90	22.50	7/80	78	60	7/80	9.60
1981	204	51	102	25.50	7/81	89	60	7/81	11.00
1982	260	65	130	32.50	7/82	113	75	7/82	12.20

1983	304	76	152	38.00		113	75		12.20
1984	356	89	178	44.50	1/84	155	75	1/84	14.60
1985	400	100	200	50.00	1/85	174	75	1/85	15.50
1986	492	123	246	61.50	1/86	214	75	1/86	15.50
1987	520	130	260	65.00	1/87	226	75	1/87	17.90
1988	540	135	270	67.50	1/88	234	75	1/88	24.80
1989	[9] 560	NA	NA	[10] 25.50	1/89	156	75	1/89	31.90
1990	592	148	296	74.00	1/90	175	75	1/90	28.60
1991	628	157	314	78.50	1/91	177	100	1/91	29.90
1992 [11]	660	165	330	82.50	1/92	194	100	1/92	31.80
1993 [11]	696	174	348	87.00	1/93	209	100	1/93	36.60
1994 [11]	744	186	372	93.00	1/94	229	100	1/94	41.10
1995 [11]	800	200	400	100.00	1/95	250	100	1/95	46.10
1996 [11]	856	24	428	107.00	1/96	273	100	1/96	47.70

---

[1] For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished. For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

[2] For care in psychiatric hospital—190 day lifetime limit.

[3] Always equal to ¼ of inpatient hospital deductible through 1988, and for 1990 and later, eliminated for 1989.

[4] Always equal to ½ of inpatient hospital deductible through 1988, and for 1990 and later, eliminated for 1989.

[5] Always equal to ⅛ of inpatient hospital deductible through 1988 and for 1990 and later. For 1989 it was equal to 20 percent of estimated Medicare covered average cost per day.

[6] Not applicable prior to July 1973. Applies to individuals who are not fully insured.

[7] Not covered.

[8] For August 1973 the premium was $6.10.

[9] In 1989, the HI deductible was applied on an annual basis, not a benefit period basis (unlike the other years).

[10] In 1989, the SNF coinsurance was on days 1–8 of the 150 days allowed annually; for the other years it is on days 21–100 of 100 days allowed per benefit period.

[11] Administration projections under current law using fiscal year 1992 budget assumptions except the SMI premium for 1992–1995 was legislated.

Note: In addition to the deductible and coinsurance amounts shown in the table, the first 3 pints of blood are not reimbursed by Medicare. Currently there is no deductible or coinsurance on home health benefits. From January 1973 to June 30, 1982, there was a $60 annual deductible and prior to July 1, 1981, benefits were limited to 100 visits per benefit period under part A and 100 visits per calendar year under part B. Special limits apply to certain benefits: (1) Outpatient physician services for mental illness: 50 percent of approved charges with a maximum reimbursement July 1, 1966 through December 31, 1987, $250 per year; January 1, 1988 through December 31, 1989, $450 per year; January 1, 1990 and thereafter, no maximum; (2) Physical therapy services furnished by physical therapists in independent practice: Maximum annual approved charges July 1, 1973, through December 31, 1981, $100 per year; January 1, 1982 through December 31, 1989, $500 per year, January 1, 1990 and thereafter, $750 per year.

Source: Health Care Financing Administration, Office of the Actuary, Office of Medicare Cost Estimates.

COVERAGE

Most individuals establish entitlement to part A on the basis of work in employment covered by either the Social Security or railroad retirement systems. Certain employment is excluded from Social Security (including part A hospital insurance) taxation.

The Tax Equity and Fiscal Responsibility Act of 1982 extended the hospital insurance tax to Federal employment effective with respect to wages paid on or after January 1, 1983. Beginning January 1, 1983, Federal employment is used to determine eligibility for protection under Medicare part A. A transitional provision allows individuals who are in the employ of the Federal Government both before and during January 1, 1983, to have their prior Federal employment considered as employment for purposes of providing Medicare coverage. Newly hired employees of State and local governments hired after March 31, 1986, are liable for the HI tax.

BENEFITS

Part A of Medicare will pay for:

1. Inpatient hospital care.—All reasonable expenses for the first 60 days minus a deductible ($628 in calendar year 1991) in each benefit period. For days 61–90, a coinsurance amount ($157 in calendar year 1991) is deducted. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60 day lifetime reserve. A coinsurance amount ($314 in calendar year 1991) is also deducted for each reserve day.

2. Skilled nursing facility care.—Up to 100 days (following hospitalization) in a skilled nursing facility for persons in need of continued skilled nursing care and/or skilled rehabilitation services on a daily basis. After the first 20 days, there is a daily coinsurance amount deducted ($78.50 in calendar year 1991).

3. Home health care.—Home health visits provided to persons who need skilled nursing care, physical therapy, or speech therapy on an intermittent basis.

4. Hospice care.—Hospice care services provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less up to a 210-day lifetime limit. A subsequent period of hospice coverage is allowed beyond the 210-day limit if the beneficiary is recertified as terminally ill.

Part B of Medicare pays 80 percent of the reasonable charges (or of reasonable cost) for covered services in excess of an annual deductible ($100). Services covered include the following:

1. Doctor's services.—Including surgery, consultation, and home, office and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists and chiropractors and for the treatment of mental illness.

2. Other medical and health services.—Laboratory and other diagnostic tests, X-ray and other radiation therapy, outpatient services at a hospital, rural health clinic services, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services.

3. Home health services.—Unlimited number of medically necessary home health visits for persons not covered under part A. The

20 percent coinsurance and $100 deductible do not apply for such benefits.

Table 4 illustrates the deductible, coinsurance and premium amounts for both part A and part B services from the inception of Medicare.

ADMINISTRATION

Responsibility for administration of the Medicare program has been delegated by the Secretary of Health and Human Services to the Administrator of the Health Care Financing Administration (HCFA). Much of the day-to-day operational work of the program is performed by "intermediaries" and "carriers" which have responsibility for reviewing claims for benefits and making payments.

In general, hospitals and other providers paid under part A of Medicare can nominate, subject to HCFA's approval, a national, State, or other public or private agency to serve as a fiscal intermediary between themselves and the Federal Government.

The Secretary enters into contracts with insurance organizations to serve as carriers. The carrier must perform its obligations under the contract efficiently and effectively and must meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent. The carrier must ensure that payments made to providers under part B on a reasonable cost or reasonable charge basis (as may be applicable) are reasonable.

Medicare administrative costs amount to approximately 2.5 percent of program outlays.

Hospitals

The Social Security Amendments of 1983 (Public Law 98-21) altered the way in which Medicare pays hospitals. From the inception of the program, Medicare had paid hospitals on a "reasonable cost" basis. Effective October 1, 1983, Medicare began paying under a prospective payment system. Medicare payments for inpatient operating costs of hospitals are determined in advance and made on a per discharge basis. A fixed amount per case is paid based upon the type of case or "diagnosis-related group" (DRG) into which the case is classified.

The payment system is not applied to capital-related costs, direct medical education costs, and certain other costs. These expenses continue to be reimbursed on a reasonable cost basis. Capital costs may no longer be excluded from the system beginning October 1, 1991. Certain hospitals are excluded from the system: psychiatric, long-term care, children's and rehabilitation hospitals. Excluded hospitals continue to be paid based on reasonable costs subject to certain rate of increase limitations.

Additional payments are made for extraordinarily costly cases, for the indirect costs of medical education, and for hospitals serving a disproportionate share of low income patients. An adjustment is made for the wage level in the area in which the hospital is located. In addition, there are certain other exceptions and adjustments including those for sole community providers, national and regional referral centers, and cancer treatment centers.

The prospective payment system was phased in over 4 years from payments based on an individual hospital's historical costs to payments based on the new payment rates. In addition, the system was phased in from payments representing nine regional payment levels to one national payment level for each DRG. There are separate payment levels for large urban, other urban, and rural areas.

Hospitals and other institutional providers receiving payment under Medicare part A submit bills on behalf of the beneficiary and agree to accept the program's payment as payment in full. In general, providers are permitted to charge beneficiaries only the deductible and coinsurance amounts authorized by law.

Physicians

Medicare part B provides insurance coverage for physician services and for certain other medical services. To be entitled to benefits under Medicare part B, individuals eligible for hospital benefits under part A must enroll in part B and pay a monthly premium.

Payments are made for services covered under part B after an annual deductible requirement of $100 has been satisfied. Payment is set at 80 percent of the Medicare approved "reasonable" charge. Beneficiaries are responsible for the remaining 20 percent as coinsurance.

For physicians' services, the Medicare approved reasonable charge is limited to the lowest of the following amounts: (1) the physician's actual charge for the service; (2) the physician's customary charge for the service; or (3) the prevailing charge for the service as provided by physicians in a particular locality. Since 1973, annual increases in prevailing charge levels have been limited by the Medicare Economic Index (MEI). The index reflects year-to-year changes in general wage levels and physician practice costs. Customary and prevailing charge screens generally are updated every year. However, payments were temporarily frozen from July 1, 1984 to December 31, 1986.

In limited situations, the Secretary of Health and Human Services may make an adjustment in payment levels if he determines that application of the standard payment methodology results in a payment level that is not "inherently reasonable." Standards and procedures for application of the inherent reasonableness authority are specified by statute. Based on similar considerations, Congress has required a reduction in payment for cataract surgery and related anesthesia services effective January 1, 1987, and has required reductions in certain other procedures effective April, 1, 1988. Beginning in 1990, the law required reductions in payments for a number of overvalued procedures. The reductions are continued in 1991 and the list of procedures subject to reduction is expanded.

Medicare payment is made either on an "assigned" or "unassigned" basis. By accepting assignment, physicians agree to accept the Medicare approved charge as payment-in-full. Thus, if assignment is accepted, beneficiaries are not liable for any out-of-pocket costs other than standard deductible and coinsurance payments. In contrast, if assignment is not accepted, beneficiaries may be liable for charges in excess of the Medicare approved charge, subject to certain limits.

Medicare's participating physician program was established in 1984 to provide beneficiaries with the opportunity to select a physician who has agreed to accept assignment on all services provided during a 12-month period. Nonparticipating physicians continue to be able to accept or refuse assignment on a claim-by-claim basis. A number of incentives are provided to encourage physicians to sign participation agreements. These include: higher prevailing charge screens, more rapid claims payment, and wide-spread distribution of participating physician directories.

To ensure that limitations on Medicare payments do not result in higher out-of-pocket costs for beneficiaries, the actual charges of nonparticipating physicians were limited during a 4-year period beginning on January 1, 1987. Under the maximum allowable actual charge (MAAC) limits, nonparticipating physicians with actual charges in excess of 115 percent of the prevailing charge were limited to a 1 percent a year increase in their actual charges. Nonparticipating physicians with lower actual charges could increase their charges at a more rapid rate.

In 1989, a major four-part reform of the Medicare physician payment system was enacted: (1) A resource based relative value scale will be implemented with a 5-year phase-in beginning on January 1, 1992. (2) Overall limit on the increase in physician expenditures will be implemented in 1990 through Medicare Volume Performance Standards (MVPS). (3) A limit on actual charges that are phased-in to 115 percent of the fee schedule amount in 1993 will provide protection to beneficiaries from large extra-billing amounts and (4) a program of outcomes and effectiveness research is established. (Additional information concerning physician payment is included in appendix E.)

The following table 5 shows the number of participating institutions and organizations.

TABLE 5.—PARTICIPATING INSTITUTIONS AND ORGANIZATIONS (JUNE 1984, 1988, 1989, AND 1990)

	1984	1988	1989	1990
Hospitals	6,675	6,715	6,508	6,520
Short stay	6,038	5,856	5,582	5,549
Long stay	637	859	926	971
Skilled nursing facilities	5,952	7,379	8,198	8,937
Home health agencies	4,684	5,769	5,546	5,730
Independent laboratories	3,801	4,487	4,613	4,879
Outpatient physical therapy providers	791	1,030	1,082	1,195
Portable X-ray suppliers	269	395	418	443
Rural health clinics	420	459	484	551
Comprehensive outpatient rehabilitation facilities	48	141	170	186
Ambulatory surgical centers	155	852	1,096	1,197
Hospices	108	449	703	825
Facilities providing services to renal disease beneficiaries	1,335	1,701	1,888	1,992

TABLE 5.—PARTICIPATING INSTITUTIONS AND ORGANIZATIONS (JUNE 1984, 1988, 1989, AND 1990)—Continued

	1984	1988	1989	1990
Hospitals certified as both renal transplant and renal dialysis centers	147	160	164	166
Hospitals certified as renal transplant centers	16	39	50	52
Hospital dialysis facilities	117	149	163	174
Non-hospital renal dialysis facilities	645	960	1,121	1,217
Dialysis centers only	359	351	332	1,882
Inpatient care	51	42	58	52
Hospital and skilled nursing facility beds:				
Hospitals	1,144,142	1,124,928	1,103,359	1,104,574
Short stay	1,023,465	997,900	973,013	970,480
Long stay	120,677	127,028	130,346	134,094
Skilled nursing facilities	530,403	449,867	492,999	508,585

Source: Health Care Financing Administration, BDMS, Division of Information Analysis.

END STAGE RENAL DISEASE PROGRAM

In 1972, Public Law 92-603 extended Medicare coverage for certain individuals with renal failure. The Medicare program covers individuals, under age 65, who suffer from end stage renal disease, if they are (1) fully insured for old age and survivor insurance benefits, or (2) are entitled to monthly social security benefits, or (3) are spouses or dependents of individuals described in (1) or (2). Such persons must be medically determined to be suffering from end stage renal disease and must file an application for benefits. Approximately 7 percent of the population suffering from end stage renal disease (ESRD) do not meet any of these requirements and thus is not covered for Medicare renal benefits.

Benefits for qualified end stage renal disease beneficiaries include all part A (hospital insurance) and part B (supplementary medical insurance) medical items and services. ESRD beneficiaries are automatically enrolled in the part B portion of Medicare and must pay the monthly premium for such protection.

Table 6 shows estimates of expenditures, number of beneficiaries, and the average expenditure per person from 1974 through 1995. Total projected program expenditures for Medicare end stage renal disease program for fiscal year 1990 are estimated at $3.6 billion excluding Medicare part A hospital services that are reimbursed on a cost basis, such as capital and the costs of acquiring organs. In fiscal year 1990, there are projected to be 143,976 ESRD beneficiaries including successful transplant patients, and also including persons entitled to Medicare on the basis of disability who also have ESRD.

When the ESRD program was created, it was assumed that program enrollment would level out at about 90,000 enrollees by 1995.

That mark was passed several years ago, and no indication exists that enrollment will stabilize soon.

TABLE 6.—ESRD MEDICARE BENEFICIARIES AND PROGRAM EXPENDITURES

[Expenditures in millions]

Fiscal Year	HI & SMI Expenditures	HI Beneficiaries	Per person
1974	$229	15,993	$14,300
1975	361	22,674	15,900
1976	512	28,941	17,700
1977	641	35,889	17,900
1978	800	43,482	18,400
1979	1,010	52,636	19,200
1980	1,250	60,814	20,600
1981	1,472	68,288	21,500
1982	1,651	70,303	23,484
1983	1,758	79,422	22,135
1984	1,889	88,849	21,261
1985	2,070	98,181	21,084
1986	2,348	107,594	21,823
1987	2,505	117,341	21,348
1988	2,738	126,929	21,571
1989	3,154	135,545	23,269
1990	3,554	143,976	24,685
1991	3,945	152,600	25,852
1992	4,392	161,474	27,199
1993	4,879	170,537	28,610
1994	5,431	179,638	30,233
1995	6,051	188,662	32,073

Note: Estimates for 1982–95 are subject to revision by the Office of the Actuary, Office of Medicare Cost Estimates; projections for 1991–95 are under the fiscal year 1992 budget assumptions.

Source: Office of the Actuary, Health Care Financing Administration, Department of Health and Human Services, for fiscal years 1982–95.

Table 7 shows that new enrollment grew an average annual rate of 9.0 percent from 1980 to 1988. Most of the growth in program participation is attributable to growth in the numbers of elderly people receiving services and growth in the numbers of more seriously ill people entering treatment. Table 7 shows the greatest rate of growth in program participation in people over age 75, at 18.4 percent, followed by the second highest rate of growth in people ages 65 to 74 years old. This age group exhibited a growth rate of 11.6 percent. The largest rate of growth in primary diagnosis of people entering treatment was diabetes. People with diabetes frequently have multiple health problems, making treatment for renal failure more difficult.

TABLE 7.—MEDICARE END STAGE RENAL DISEASE PROGRAM NEW ENROLLMENTS BY AGE AND PRIMARY DIAGNOSIS: 1980–88

Age and primary diagnosis	1980	1981	1982	1983	1984	1985	1986	1987	1988	Average annual percent change	Percent change 1987–1988
Number of new enrollees:											
Total	18,404	19,307	21,815	25,155	26,552	29,419	31,561	34,273	36,743	9.0%	7.2
Age:											
Under 15 years	374	336	414	380	427	416	425	427	400	0.8	−6.3
15–24 years	1,091	1,115	1,170	1,103	1,159	1,186	1,181	1,231	1,254	1.8	1.9
25–34 years	2,092	2,189	2,458	2,466	2,624	2,707	2,975	2,837	3,052	4.8	7.6
35–44 years	2,244	2,368	2,595	2,838	3,017	3,382	3,647	3,959	4,287	8.4	8.3
45–54 years	3,167	3,234	3,529	3,755	3,877	4,222	4,422	4,834	5,318	6.7	10.0
55–64 years	4,346	4,713	5,263	5,773	6,283	6,902	7,099	7,733	8,227	8.3	6.4
65–74 years	3,746	3,939	4,574	6,067	6,190	7,078	7,703	8,606	9,028	11.6	4.9
75 years and over	1,344	1,413	1,812	2,773	2,975	3,526	4,109	4,646	5,177	18.4	11.4
Diagnosis:											
Diabetes	2,225	3,620	4,989	5,913	7,112	8,192	9,290	10,234	11,247	22.5	9.9
Glomerulonephritis	2,208	3,437	5,093	4,101	4,362	4,575	4,687	4,902	5,087	11.0	3.8
Hypertension	2,453	3,918	5,368	5,815	6,527	7,450	7,865	8,932	9,826	18.9	10.0
Polycystic-kidney disease	602	832	1,012	1,053	1,063	1,153	1,208	1,229	1,209	9.1	−1.6
Other/unknown	10,916	7,500	5,353	8,273	7,488	8,049	8,511	8,976	9,374	−1.9	4.4

Source: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Program Management and Medical Information System, March 1990 update.

The rates of growth in older and sicker patients entering treatment for end stage renal disease indicate a shift in physician practice patterns. In the past, most of these people would not have entered dialysis treatment because their age and severity of illness made successful treatment for renal failure less likely. Although the reasons that physicians have begun treating older and sicker patients are not precisely known, it is clear that these practice patterns have, and will continue, to result in steady growth in the numbers of patients enrolling in Medicare's end stage renal program.

End stage renal disease is invariably fatal without treatment. Treatment for the disease takes two forms: transplantation and dialysis. Although the capability to perform transplants had existed since the 1950's, problems with rejection of transplanted organs limited its application as a treatment for renal failure. The 1983 introduction to the market of a powerful and effective immunosuppressive drug, cyclosporine, resulted in a dramatic increase in the numbers of transplants being performed and the success rate of transplantation.

Table 8 indicates that the number of transplants in 1989 was more than double the number performed in 1979. The number of transplants performed increased steadily through 1986 before leveling off. The rate of successful transplantation has increased even more dramatically; from 1980 to 1985, the number of Medicare patients with successful transplants increased at an average annual rate of 20.3 percent. Despite the significant increases in the number and success of kidney transplants, transplantation will not be the treatment of choice for all ESRD patients. A chronic, severe shortage of kidneys available for transplantation now limits the number of patients who can receive transplants. Even absent a shortage of organs, some patients are not suitable candidates for transplants because of their age, severity of illness or other complicating conditions. And some ESRD patients do not want an organ transplant.

For all of these reasons, dialysis is likely to remain the primary treatment for end stage renal disease. Dialysis is an artificial method of performing the kidney's function of filtering blood to remove waste products. There are two types of dialysis: hemodialysis and peritoneal dialysis. In hemodialysis, still the most common form of dialysis, blood is removed from the body, filtered and cleansed through a dialyzer, sometimes called an artificial kidney machine, before being returned to the body. Peritoneal dialysis does not require use of a machine. Instead, filtering takes place inside the body by inserting dialysate fluid through a permanent surgical opening in the peritoneum (abdominal cavity). Toxins filter into the dialysate fluid and are then drained from the body through the surgical opening. To be effective, both types of dialysis generally need to be performed several times a week, usually three times.

TABLE 8.—TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE CERTIFIED U.S. HOSPITALS

Calendar year	Total transplants	Living donor		Cadaveric donor	
		Number	Percent	Number	Percent
1979	4,189	1,186	28	3,003	72
1980	4,697	1,275	27	3,422	73
1981	4,883	1,458	30	3,425	70
1982	5,358	1,677	31	3,681	69
1983	6,112	1,784	29	4,328	71
1984	6,968	1,704	24	5,364	76
1985	7,695	1,876	24	5,819	76
1986	8,976	1,887	21	7,089	79
1987	8,967	1,907	21	7,060	79
1988	8,932	1,760	20	7,116	80
1989	8,899	1,893	21	7,006	79

Source: HCFA, BDMS, Division of Information Analysis.

Since 1983, Medicare has reimbursed outpatient maintenance dialysis on the basis of a fixed rate which is adjusted to reflect the proportion of patients dialyzing at home. Separate rates are established for hospitals and for independent, or free-standing, facilities. Both rates were originally derived from audited costs; both are divided into nonlabor and labor components. The labor component is adjusted by a wage index to reflect differences in wages. In addition, the hospital rate contains two additional adjustments which result in slightly higher rates. One adjustment consists of a 5 percent add-on to the overall rate to account for possible data collection errors, and the second adjustment consists of a $2.10 add-on per treatment to account for hospitals' additional overhead. The fixed rate is paid for each treatment.

When this rate structure was implemented in 1983, HCFA estimated that the average payment for independent facilities would be around $127 per treatment and the average payment to hospitals would be approximately $131. In 1986, HCFA proposed to lower the rates, based on 1983 audit data which showed declining costs. The rates HCFA proposed to implement would have resulted in an average rate of $115.40 for independent facilities and an average rate of $119.70 for hospital-based facilities. OBRA 1986 preempted the implementation of these rates by reducing each rate by $2.00. In OBRA 1989, Congress required that these rates be maintained until October 1, 1990. OBRA 1990 increased rates by $1, effective January 1, 1991.

The effect of a dialysis rate that has been either fixed or declining since 1983 is less real spending per enrollee on dialysis services. Adjusting for inflation, dialysis reimbursement rates were nearly 60 percent lower in 1988 than they were in 1974. Considerable evidence documents increasing efficiency and lower costs associated with dialysis, but concerns that the rates have adversely affected quality and access to care remain. In OBRA 1987, Congress authorized the Institute of Medicine to conduct a comprehensive study of the ESRD program and the effects of the composite rate. That report was due to Congress at the end of 1990.

Recent changes

Dialysis payment rates.—OBRA 1989 mandated the continuance of the dialysis rates then in effect until October 1, 1990. In addition, it required the Secretary to follow standard regulatory procedures when proposing rate changes. OBRA 1990 increased the dialysis rates in effect on September 30, 1990, by $1 for services provided on or after January 1, 1991. It also directed the Prospective Payment Assessment Commission to conduct a study to determine the costs, services and profits associated with various dialysis treatment modalities. The Commission is to make recommendations to Congress by June 1, 1992, on methods and levels of reimbursement for dialysis services. In addition to this study, OBRA 1990 directed ProPAC to make a recommendation to Congress on an appropriate factor to be used in updating payments for services. ProPAC is to submit its recommendations to Congress by March 1 of each year for the succeeding fiscal year, with the first recommendation due March 1, 1992.

Limitation of method II payments for home dialysis.—In January 1989, HCFA proposed to limit payments (called method II payments) to suppliers who deal directly with Medicare beneficiaries rather than providing supplies through an approved Medicare dialysis facility. HCFA's proposed rule was in response to information that one supplier received monthly payments nearly twice as high as facilities received for dialyzing patients, either in-facility or at home. These rules were not implemented.

Subsequently, the General Accounting Office conducted a study of method II payments. GAO concluded that the differential in payments between method I (payments to dialyis facilities for home dialysis patients) and method II suppliers was not justified. Shortly after GAO's report was released, Congress incorporated GAO's recommendations by enacting a payment limit on method II payments in OBRA 1989. The new limit is 100 percent of the median dialysis rate paid to hospital-based facilities. In the case of home patients on continuous cycling peritoneal dialysis (CCPD), the limit is 130 percent of the median hospital-based dialysis rate. The payment limit took effect on February 1, 1990.

Staff-assisted home dialysis demonstration project.—In response to continuing congressional concerns about some home dialysis patients' needs for staff assistance after the limitation on method II payments was imposed, OBRA 1990 established a 3-year demonstration project to determine whether Medicare coverage of staff assistants could be both cost effective and safe for patients. The demonstration is to begin within 9 months of OBRA 1990's enactment for a maximum of 800 participants. The law defines staff assistant services as including: technical assistance with operating the hemodialysis machine and care of patients during home dialysis; and administration of medications in patients' homes. Home dialysis staff assistants must meet minimum requirements specified by the Secretary and any State requirements applicable in the State where the staff assistant practices.

The law establishes rather stringent patient eligibility criteria designed to assure that the demonstration is limited to patients whose health status precludes travel to a dialysis facility and whose family members are not able to assist them with home dialysis.

Payments to an ESRD provider or dialysis facility participating in the demonstration project are to be prospectively determined by the Secretary, made on a per treatment basis, and paid as an add-on to the dialysis rate. OBRA 1990 provides detailed instructions on calculating the payment rate for staff assistants. The payment structure is designed to prevent duplicate payments for labor costs, since the dialysis rate structure already includes labor costs associated with providing in-facility dialysis.

OBRA 1990 provides funding of $4 million in fiscal years 1991 and 1992 for the demonstration; $3 million in fiscal year 1993; $2 million in fiscal year 1994; and $1 million in fiscal year 1995. The Secretary is directed to submit a preliminary report on the status of the demonstration by December 1, 1992, and a final report by December 31, 1995. The final report is to evaluate the demonstration project and include recommendations regarding eligibility criteria and cost-control mechanisms for providing Medicare coverage of home dialysis aides.

Reimbursement for epoetin.—On June 1, 1989 the U.S. Food and Drug Administration (FDA) approved marketing of a drug used to treat anemia associated with chronic renal failure. The drug, epoetin, is a genetically engineered copy of a protein (erythropoietin or EPO) that the body uses to stimulate production of red blood cells. EPO is used as a substitute for transfusions. Medicare began reimbursing for the drug for chronic renal failure patients with a specified level of anemia in 1989. Chronic renal failure patients may include those not on dialysis or transplant patients as long as they have the specified level of anemia.

In a break with longstanding policy, Medicare's reimbursement rate for EPO was negotiated in advance of FDA approval and was set at about 80 percent of the anticipated market price. Concern about the eventual costs that EPO would add to ESRD expenditures played a major role in HCFA negotiation of a Medicare reimbursement rate below market price.

Reimbursement for the drug varies by the setting in which it is administered. If administered in an approved ESRD facility (either a hospital or an independent facility), payment is made as an add-on to the dialysis rate. For each administration of the drug of less than 10,000 units, the additional payment was initially set at $40. For patients requiring more than 10,000 units, a payment of $30 was initially made, which was an addition to the $40 payment. The maximum payment was $70.

Physicians receiving monthly capitation payments for providing services to ESRD patients are reimbursed for drug costs but are not given any additional reimbursement for administering the drug. However, they are reimbursed an additional $2 per treatment for supplies, such as syringes. HCFA suggested that reimbursement for actual drug costs be based on drug prices reported in the Drug Topics red book, blue book or Medispan manuals, although, as a matter of practice, some carriers reimburse drug costs based on actual invoices.

Prior to implementing Medicare coverage of EPO, budget estimators had no reliable basis on which to estimate the number of ESRD patients who would use it. HCFA's preliminary estimate was that about 25 percent (25,000 to 30,000) of dialysis patients would use it in the first year of coverage, but that approximately 80 percent (75,000 to 80,000) of dialysis patients would use it by 1994 or 1995. The total yearly costs of providing the drug per user were estimated at $5,600, with Medicare paying $4,480 and the remaining $1,120 paid by other insurers or beneficiaries.

Medicare claims for dialysis patients processed for October 1990 indicate that the dose per treatment averaged about 2,775 units and Medicare's approved charge averaged about $43 per treatment. A total of 53,213 ESRD patients received an average of 12 doses that month. At the end of October 1990, Medicare had paid a total of $21.8 million for EPO treatments.

OBRA 1990 revised payments made to dialysis facilities for EPO by establishing payment rates per 1,000 unit increments; abolishing the $70 payment cap; and indexing EPO payment rates for subsequent years. Effective January 1, 1991, payments to dialysis facilities for EPO are limited to $11 per 1,000 unit increments, rounded to the nearest 100 units. In 1992 and subsequent years, payment rates for EPO will be increased by the percentage increase (if any) in the implicit price deflator for the gross national product (GNP). No changes were made to the method of reimbursing physicians for administration of the drug.

OBRA 1990 also extended coverage for self-administration of EPO to home dialysis patients if they are competent to administer it without medical or other supervision. The Secretary is to develop methods and standards to determine who is competent to self-administer the drug. Payments for EPO on behalf of home dialysis patients who self-administer EPO are made on the same basis as payments to facilities. This includes payments to suppliers on behalf of method II patients. Coverage for self-administration of EPO will become effective for services provided on or after July 1, 1991.

Medicare spending for ESRD services

Table 9 shows overall per capita Medicare spending by type of ESRD patient from 1984–88. There are four types of ESRD patients: (1) dialysis patients, who constitute 78 percent of total ESRD patients; (2) transplant patients, who constitute 5 percent of the total; (3) functioning graft (successful transplant) patients, who constitute 16 percent of the total; and (4) graft failure (failed transplant) patients, who comprise 1 percent of the total. Dialysis patients are those on dialysis during the year in question. Transplant patients are those who received a transplant during that year. Functioning graft patients are recipients of successful transplants performed during a previous year, and graft failure patients are those who received a transplant during a prior year, but whose transplants failed during the year in question.

Per capita spending for ESRD patients averaged $23,270 in 1988, but spending varied significantly by type of patient. Patients with successful transplants had the lowest average annual expenditures at $6,144, followed by dialysis patients at $24,367. Patients whose transplants failed had significantly higher annual costs at $34,571. The highest costs were reported for patients who had a transplant during the year in question; their 1988 per capita costs were reported at $58,023. If their transplants are successful over the long run, however, these patients are ultimately less expensive to serve because they no longer need either expensive acute care or chronic dialysis services.

TABLE 9.—MEDICARE END STAGE RENAL DISEASE PROGRAM EXPENDITURES BY PATIENT TREATMENT GROUP: 1984–88

	1984	1985	1986	1987	1988	Average annual percent change
All Persons						
Number of persons	113,542	125,378	136,957	148,771	161,084	9.1
Expenditures (per person):						
Total	$20,972	$21,376	$22,698	$23,134	$23,270	2.6
Inpatient	9,074	9,696	10,477	10,522	10,710	4.2
Outpatient	8,085	7,635	7,861	7,914	7,816	−0.8
Physician/Supplier	3,711	3,928	4,242	4,584	4,627	5.7
Other [1]	103	117	117	114	117	3.2
Dialysis Patients						
Number of persons	93,695	101,951	109,060	116,858	125,724	7.6
Expenditures (per person):						
Total	$21,220	$21,626	$23,051	$23,932	$24,367	3.5
Inpatient	8,013	8,498	9,133	9,403	9,788	5.1
Outpatient	9,205	8,813	9,214	9,394	9,341	0.4
Physician/Supplier	3,889	4,184	4,574	5,008	5,108	7.1
Other [1]	114	132	129	127	131	3.5
Transplant Patients						
Number of persons	6,312	7,026	8,274	8,235	8,114	6.5
Expenditures (per person):						
Total	$44,835	$50,370	$53,408	$55,495	$58,023	6.7
Inpatient	32,795	38,543	41,165	42,587	44,750	8.1
Outpatient	6,099	5,750	5,910	6,096	6,322	0.9
Physician/Supplier	5,957	6,035	6,248	6,752	6,865	3.6
Other [1]	47	57	73	73	86	16.3
Functioning Graft Patients						
Number of persons	12,504	15,298	18,408	22,181	25,603	19.6
Expenditures (per person):						
Total	$6,030	$5,720	$6,154	$6,181	$6,144	0.5
Inpatient	4,231	3,890	4,112	3,909	3,851	−2.3
Outpatient	656	628	701	766	785	4.6
Physician/Supplier	1,096	1,157	1,282	1,443	1,441	7.1

TABLE 9.—MEDICARE END STAGE RENAL DISEASE PROGRAM EXPENDITURES BY PATIENT TREATMENT GROUP: 1984–88—Continued

	1984	1985	1986	1987	1988	Average annual percent change
Other [1]	48	52	60	63	62	6.6
Graft Failure Patients						
Number of persons	1,031	1,103	1,215	1,497	1,643	12.4
Expenditures (per person):						
Total	$33,269	$30,644	$32,428	$34,068	$34,571	1.0
Inpatient	19,011	17,316	18,519	19,506	19,963	1.2
Outpatient	8,632	7,978	8,066	8,283	8,095	−1.6
Physician/Supplier	5,529	5,349	5,679	6,146	6,391	3.7
Other [1]	97	91	82	67	122	5.9

[1] Other includes skilled nursing facility and home health services.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Program Management and Medical Information System, and the Medicare Automated Data Retrieval System, March 1990 Update, 1984–88.

HOME HEALTH

The hospital insurance (part A) and the supplementary medical insurance (part B) programs cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Persons must also be homebound. The home health benefit is not subject to deductibles or copayments. When an individual is covered under parts A and B of the Medicare program, the individual will generally receive payment for home health services under part A of the program. In 1988, Medicare covered an average of 24 home health visits for persons who qualified for the benefit.

Reimbursement to home health agencies is based on Medicare rules for reasonable cost reimbursement. However, home health agencies are required to use the cost per visit by type of service for apportioning costs. Under this method, the total allowable costs of all visits for each type of service (skilled nursing, home health aide, etc.) is divided by the total number of visits by type of service. These average cost per visit amounts are multiplied by the number of covered Medicare visits for each type of service. The products represent the cost Medicare will recognize by type of service, subject to home health agency cost limits.

In 1986, Public Law 99–509 established the current methodology for determining home health care limits. These are set at 112 percent of the mean of the labor-related and nonlabor per unit costs for each type of service provided by freestanding home health agencies. The limits are then applied on an aggregate basis to all the visits made by the agency, with appropriate adjustments for the special costs of hospital-based agencies.

Until recently the Medicare home health benefit was the fastest growing part of the Medicare program. Table 10 below indicates the increase in Medicare program expenditures for home health care.

TABLE 10.—TOTAL MEDICARE HOME HEALTH BENEFIT PAYMENTS

[Dollars in millions] [1]

Fiscal year	Reimbursements			Percent change from prior year	Visits per 1,000 enrollees [2]	Average charge per visit [2]
	Part A	Part B	Total			
1969	NA	NA	$77	....	232	$13
1970	NA	NA	89	15.6	222	14
1971	NA	NA	95	6.7	164	16
1972	NA	NA	97	2.1	168	17
1973	NA	NA	95	−2.1	189	18
1974	NA	NA	136	43.2	211	21
1975	NA	NA	207	52.2	271	24
1976	NA	NA	312	50.7	347	27
1977	NA	NA	406	30.1	419	29
1978	NA	NA	498	22.7	464	32
1979	NA	NA	592	18.9	515	34
1980	NA	NA	726	22.6	577	36
1981	NA	NA	914	25.9	713	40
1982	NA	NA	1,177	28.8	1,024	44
1983	NA	NA	1,538	30.7	1,227	47
1984	NA	NA	1,866	21.3	1,344	50
1985	$2,119	$53	2,172	16.4	1,329	55
1986	2,194	47	2,241	3.2	1,256	58
1987	2,287	48	2,335	4.2	1,153	61
1988	2,257	56	2,313	−0.9	1,143	64
1989	2,515	48	2,563	10.8	1,319	64
1990	3,400	73	3,473	35.5	1,648	66
1991	3,754	54	3,808	9.6	1,661	70
1992	4,118	61	4,179	9.7	1,672	74
1993	4,496	68	4,564	9.2	1,683	79
1994	4,869	76	4,945	8.3	1,694	84
1995	5,246	85	5,331	7.8	1,706	88
1996	5,649	95	5,744	7.7	1,720	93

[1] Based on fiscal year 1992 President's Budget assumptions. All numbers in this table were revised slightly by HCFA from this table in the 1990 Green Book edition.

[2] Based on Part A alone.

NA—Not available.

Source: Health Care Financing Administration, Division of Budget.

HOSPICE CARE

Public Law 97-248 authorized Medicare part A coverage for hospice care services provided to individuals who are entitled to Medicare part A benefits and who are certified to be terminally ill. In 1986, the Congress in Public Law 99-272 made the hospice benefit a permanent part of the Medicare program effective April 7, 1986.

On December 16, 1983, the Health Care Financing Administration (HCFA), published regulations to implement the hospice provisions of Public Law 97-248. Among other things, the regulations establish requirements for eligibility, covered benefits, services, reimbursement procedures, and the conditions a hospice must meet to be approved for participation in the Medicare program.

Part A beneficiaries may elect to receive hospice care in lieu of most other Medicare benefits for up to two periods of 90 days each, a subsequent period of 30 days, and an additional extension period if elected.

The statute provides that payment to hospice providers be equal to the costs which are reasonable and related to the cost of providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe, subject to a "cap amount." The cap amount for a beneficiary for a year was established at $6,500, adjusted annually by the medical component of the CPI. The cap for the period November 1, 1989 through October 31, 1990 is $9,787.

HCFA has implemented a prospective payment methodology for hospice care. Under this methodology, hospices are paid one of four predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates vary according to the level of care furnished to the beneficiary. Total reimbursement to a hospice for care furnished to the Medicare beneficiary will vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) furnished to the beneficiary.

Four basic payment categories are used for reimbursing hospices. The payment rates are national rates which are adjusted by the Bureau of Labor Statistics wage index for an area. The published payment rates are:

(a) *Routine home care day.*—Routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate is paid for every day a patient is at home and under the care of the hospice regardless of the volume or intensity of the services provided on any given day as long as less than 8 hours of care are provided. Currently, this rate is $79.74.

(b) *Continuous home care day.*—A continuous home care day is a day on which an individual who has elected to receive hospice care receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished only during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. Home care must be provided for a period of at least 8 hours before it would be considered to fall within the category of continuous home care. Payment for continuous home care will vary depending on the number of hours of continuous services provided. Currently this rate is $465.40 for 24 hours or $19.39 per hour.

(c) *Inpatient respite care day.*—An inpatient respite care day is one on which the individual who has elected hospice care receives care in an approved facility on a short-term (not more than 5 days at a time) basis for the respite of his caretakers. Currently this rate is $82.48.

(d) *General inpatient care day.*—A general inpatient care day is one on which an individual who hae clected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. Care may be provided in a hospital, skilled nursing facility or inpatient unit of a freestanding hospice. Currently this rate is $354.73

Public Law 101-239 required that the payment rates be increased by the hospital market basket percentage increase each fiscal year.

TABLE 11.—ESTIMATES OF HOSPICE PROGRAM DATA

	Admissions	Days per admission	Cost per hospice day	Cost per admission	Total cost (oulays in millions)
Fiscal year:					
1984	2,200	29	$62	$1,800	$2
1985	11,000	33	66	2,200	15
1986	28,012	37	66	2,442	35
1987	68,721	41	74	3,034	63
1988	84,770	44	74	3,256	90
1989	89,008	48	74	3,470	211
1990	102,359	51	85	4,245	320
1991	112,595	53	93	4,828	465
1992	120,477	55	98	5,270	605
1993	126,501	57	103	5,749	760
1994	132,826	59	108	6,258	920
1995	139,467	61	114	6,811	1,100

Source: 1984–1989: CBO estimates; 1990–1995: CBO baseline projections, January, 1990.

SKILLED NURSING FACILITY

Medicare's part A hospital insurance program covers 100 days of skilled nursing facility (SNF) care for persons who can demonstrate a need for daily skilled nursing care for a condition related to a prior hospitalization. The first 20 days of SNF care are paid in full by the program. Days 21 through 100 are subject to a copayment of $78.50 a day. In 1987 Medicare covered an average of 22 days of care for those persons who qualified for the benefit.

In general, SNFs are reimbursed on the basis of reasonable costs subject to certain limits. For SNFs, limits are applied to the per diem routine service costs (nursing, room and board, administrative, and other overhead) of a facility. Capital-related and ancillary costs, such as physical therapy and drugs, are excluded from the cost limits. Separate limits are established for SNFs on the basis of whether they are freestanding or hospital-based facilities and whether they are located in urban or rural areas. Freestanding SNF cost limits are set at 112 percent of the average per diem labor-related and nonlabor costs. Hospital-based SNF cost limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limit and 112 percent of the average per diem routine service costs of hospital-based SNFs.

Public Law 99-272 established a prospective payment rate system for certain SNFs that elect such payment for cost reporting periods beginning on or after October 1, 1986. SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year would have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate is separately calculated for urban and rural areas and the prospective per diem rate also reflects wage differences between urban and rural areas within each region. These rates cannot exceed the per diem cost limit that would otherwise be applicable to that facility and cannot exceed its cost limit adjusted for capital costs.

Several important changes occurred in the SNF program during 1988 and 1989. First, in April 1988, HCFA issued a new manual to the carriers that was designed to clarify the SNF eligibility requirements. Increases in monthly SNF outlays and anecdotal information strongly suggested that the manual clarifications increased eligibility. Before this manual was issued, monthly outlays for Medicare SNF's were approximately $60 million per month. By the end of 1988, they had risen to almost $100 million per month.

TABLE 12.—SKILLED NURSING FACILITY DATA

Fiscal year	Number of SNF facilities	Total covered days of care (thousands)	Total interim reimbursement (thousands)	Interim reimbursement per day
1977	4,461	9,757.7	314,148	32
1978	4,982	9,231.1	317,472	34
1979	5,055	8,642.0	329,388	38
1980	5,155	8,701.0	358,508	41
1981	5,295	8,678.2	393,939	45
1982	5,510	8,696.2	425,251	49
1983	5,760	9,277.4	465,341	50
1984	6,183	9,546.9	489,722	51
1985	6,725	9,114.1	509,714	56
1986	7,065	8,454.1	516,422	61
1987	7,148	7,524.9	545,325	72
1988	7,379	9,378.6	727,492	78
1989 [1]	8,201	25,576.1	2,527,846	99

[1] Data are considered preliminary.

Data derived from Medicare Statistical System (MSS), Current Utilization Series Table 8, 11/30/90 Update.

Second, in June 1988 the Medicare Catastrophic Coverage Act of 1988 was enacted. The Medicare catastrophic legislation (1) removed the requirement that a Medicare beneficiary had to be in the hospital for at least 3 days prior to entering a SNF, (2) instituted a daily coinsurance payment in 1989 of $25.50 for the first 8 days (formerly no copayments were required for the first 20 days), (3) eliminated the coinsurance a beneficiary would have to pay after 8 days (formerly copayments of one-eighth of the hospital deductible of $70 in 1989 were required for days 21–100), and (4) changed the number of days that a person could receive the benefit from 100 days per spell of illness to 150 days per year. These changes were effective January 1, 1989. Monthly SNF spending rose rapidly from $97 million in January 1989 to $280 million in November 1989. Congress subsequently repealed all the legislative changes made in the SNF benefit when it repealed the Medicare Catastrophic Coverage Act. In 1991, the copayment required for days 21–100 is $78.50.

DURABLE MEDICAL EQUIPMENT

The Omnibus Budget Reconciliation Act of 1987 substantially revised Medicare's reimbursement of durable medical equipment (DME). Prior to the enactment of OBRA 1987, reimbursement for DME was made on the basis of reasonable costs to hospital outpatient departments and other providers, such as skilled nursing homes, and reasonable charges to other part B suppliers. OBRA 1987 eliminated reasonable charge or reasonable cost reimbursement and replaced it with a fee schedule for all suppliers, effective January 1, 1989. OBRA 1987 also established six discrete categories of DME (sometimes referred to as the six point plan); stipulated the method by which equipment may be acquired (rental, purchase or either); and specified how fee schedule payments are to be calculated for each category.

The six categories of DME are as follows: (1) inexpensive and routinely purchased equipment; (2) items requiring frequent and substantial servicing; (3) customized equipment; (4) oxygen and oxygen equipment; (5) other non-DME items, such as prosthetics and orthotics; and (6) other DME items not included in other categories. The allowed amounts for calendar year 1989 for these categories are shown in table 13. Reimbursement for DME, regardless of the source of procurement, is limited to the lesser of actual charges or the payment amount specified for each category of equipment. Reimbursement is limited to 80 percent of the charge or payment amount.

TABLE 13.—ALLOWED AMOUNTS FOR SELECTED DURABLE MEDICAL EQUIPMENT (DME) CALENDAR YEAR 1989

Category	Allowed amounts [millions]
Capped rental [1]	$350
Customized items [2]	5
Oxygen [3]	622
Prosthetics/orthotics [4]	307
Inexpensive/routinely purchased [5]	189
Items requiring frequent maintenance [6]	75
Other [7]	275
Total	1,823

[1] Items of DME on a monthly rental basis not to exceed a period of continuous use of 15 months.

[2] Items unsuitable for grouping together for profiling due to unique nature (custom fabrication, etc.). Payment based on individual adjudication. Amount is incomplete because it only represents HCPCS E1220. Other items are not coded in HCPCS.

[3] Oxygen and oxygen equipment paid based on a monthly rate per beneficiary. Payment not made for purchased equipment except where installment payments continue.

[4] These items include other prosthetic and orthotic devices (except for items included in the categories "Customized Items" and "Items Requiring Frequent Maintenance," transcutaneous electrical nerve stimulators, parenteral/enteral nutritional supplies and equipment, and intraocular lenses). Devices in this category paid on lump sum purchase basis.

[5] Inexpensive defined as equipment for which the purchase price does not exceed $150. Routinely purchased defined as equipment that is acquired 75 percent of the time by purchase.

[6] Paid on a rental basis until medical necessity ends.

[7] This category includes medical and surgical supplies, additional ostomy supplies, enteral formulae and enteral medical supplies, orthotic devices, and vision services which were reported using procedure codes (e.g., temporary codes and local codes) not included on the list of codes for categories 1–6 (above) provided by the Health Care Financing Administration (HCFA), Bureau of Policy Development.

Source: Health Care Financing Administration (HCFA), Bureau of Data Management and Strategy. Data from the Part B Medicare Annual Data System. Codes for the categories above provided by HCFA, Bureau of Policy Development.

CATEGORIES OF DME, METHOD OF ACQUISITION AND FEE SCHEDULE PAYMENTS

Customized items.—Customized equipment is that which is constructed or substantially modified to meet the needs of an individual patient. Payment for purchase is to be made on a lump-sum basis on an amount based on the carrier's individual consideration for the item. Payment for maintenance and servicing not covered by the manufacturer's warranty is made on a lump sum based on the carrier's individual consideration for the item. Individual consideration means the payment amount the carrier considers to be appropriate for the item; there are no guidelines carriers must use in determining prices that are based on individual consideration.

Oxygen and oxygen equipment.—One payment is made monthly for oxygen and oxygen equipment. Since oxygen is a consumable item it obviously cannot be rented. Medicare does not reimburse for purchase of oxygen equipment; rental for equipment is included in the monthly payment for purchase of oxygen.

Oxygen and oxygen equipment are reimbursed under one payment formula and portable oxygen equipment is reimbursed separately. For oxygen and oxygen equipment, calculations are made for both local and regional payment amounts. Reimbursement was made on the basis of local payment amounts only in 1989 and 1990.

The local payment amount, called the "base local average monthly payment," is calculated as a carrier's total reasonable charges for oxygen or oxygen equipment during the year ending December 1986, divided by the total number of months for all beneficiaries receiving oxygen or oxygen equipment during the 12 months for which the carrier made payment.

Reimbursement for 1989 and 1990 was equal to 95 percent of the base local average monthly payment increased by the CPI for urban consumers for the year ending December 1987.

Base monthly payment amounts are subject to limitations beginning in 1991. The base monthly payment amounts recognized may not exceed 125 percent of the amount recognized for all carrier service areas in the country or be lower than 85 percent of that amount. In subsequent years, the amount may not exceed 120 percent or be lower than 90 percent of the base monthly payment amounts recognized.

The separate payment for portable oxygen equipment is based on the same reimbursement method, except that it is subject to a limit. The amount of payment for portable oxygen equipment is limited to the lesser of the calculated payment amount or the 50 percent increase for high use described below.

Both oxygen and portable oxygen payments are modified for very low and very high use. If oxygen is prescribed at flow rates of less than 1 liter per minute, the payment amount is decreased by 50 percent. For flow rates exceeding 4 liters per minute, the payment amount is increased by 50 percent.

Covered items other than durable medical equipment.—Payment for miscellaneous items, such as prosthetics and orthotics, is made on a lump sum basis for purchase. Two elements form the basic components of the reimbursement calculation. The first is the base local purchase price, which is the average reasonable charge in the locality for the purchase of the item. The second component consists of the regional purchase price, which is equal to the weighted averages of purchase prices in the region. Similar to the reimbursement scheme for oxygen, reimbursement for these items is initially based on local prices, with a transition period in which both local and regional prices are considered.

Inexpensive or frequently purchased equipment.—Inexpensive equipment is defined as equipment which does not cost more than $150 or which the Secretary determines is acquired by purchase at least 75 percent of the time. Power-driven wheelchairs fall into this category. Payment may be made either for rental or lump-sum purchase. For 1989 and 1990, the amount of payment is equal to the average charge of an item in the area for the 12-month period ending June 30, 1987, increased by the CPI for urban consumers for the 6-month period ending December 1987.

Equipment requiring frequent and substantial servicing.—This equipment, which includes items such as ventilators and aspirators, must be serviced frequently in order to avoid risk to the beneficiary's health. It may not be purchased. Monthly rental payments are equal to the average reasonable charge in the area for rental for the 12 months ending June 1987, updated by the CPI for urban consumers for the 6-month period ending December 1987. Monthly rental payments continue as long as the equipment is needed. No additional payments are made for maintenance or servicing of these items; the monthly rental payment includes servicing and maintenance.

Other items of durable medical equipment.—This category includes durable medical equipment not included in any of the categories above. Manual wheelchairs and hospital beds are the two most frequently used items in this category. These items may only be rented and are sometimes referred to as "rental cap" items. The rental payment amount is derived from local and regional prices. The local purchase price is equal to the average of the purchase prices submitted on an assigned basis for the unused item during the 6-month period ending December 1986. For 1989 and 1990, it was updated by the CPI for urban consumers for the 6-month period ending June 1987. The regional purchase price equals the weighted average of the local prices for the carriers in the region. Both the local and regional prices are updated by the CPI for urban consumers for the 12-month period ending June 1987. Reimbursement in 1989 was based only on local prices.

Reimbursement for purchase of these items is also subject to an additional payment limit, beginning in 1991. The payment amount may not exceed 125 percent of or be lower than 85 percent of the average purchase prices for all carriers in the country in that year. In subsequent years, the payment cannot be higher than 120 percent or lower than 90 percent of national average purchase prices.

Reimbursement for rental is limited to 15 continuous months, with no maintenance or rental payments allowed in the following 6 months. Suppliers are prohibited from charging for maintenance or servicing during the 6-month period following the initial 15 months. During the first month of each successive 6-month period, maintenance payments are limited to the lower of 10 percent of the purchase price or reasonable maintenance or service fees determined by the Secretary.

Monthly rental fees are equal to 10 percent of the purchase price, as determined above. Total rental payments would equal 150 percent of the purchase price for items in the rental cap category. In 1989 and 1990, the payment amount for rental may not exceed 115 percent or be less than 85 percent of the prevailing charge for renting the item in 1987, increased by the percentage increase in the CPI for urban consumers to December 1987.

RECENT LEGISLATIVE CHANGES

OBRA 1989

The Omnibus Budget Reconciliation Act of 1989 made several changes in payments for durable medical equipment, effective April 1, 1990. It eliminated all fee schedule updates for 1990; reduced fee schedule payments for seat-lift chairs and transcutaneous electrical nerve stimulators (TENS) by 15 percent; and accelerated the restriction of payment ranges permitted in 1991 and subsequent years for oxygen and oxygen equipment and other items of DME. (The restricted payment amounts are included in the payment descriptions above.)

OBRA 1989 also transferred power-driven wheelchairs from the category of other covered items of DME (the "rental cap" category) to inexpensive and routinely purchased DME. The result of this change is that such wheelchairs now could be either purchased or rented, when previously they could only be rented. The amount of payment for these wheelchairs was also reduced from 150 percent of the submitted purchase price to 100 percent of the average charges in the area. Switching power-driven wheelchairs from the rental cap category to inexpensive and frequently purchased items also eliminated payments for routine maintenance and servicing, which had been permitted when these wheelchairs were classified under the rental cap category.

OBRA 1989 directed the Secretary to issue regulations specifying criteria to be used by carriers on a case-by-case basis for determining whether to classify power-driven wheelchairs as customized items. The provision requiring the Secretary to issue regulations took effect upon enactment.

Ostomy supplies were also excluded from the definition of durable medical equipment and specifically included in the definition of home health services in OBRA 1989. Prior to the creation of fee schedules and six point plan, ostomy supplies, as a matter of practice, had been included in the provision of home health services. OBRA 1987 specifically defined them as durable medical equipment and stipulated that payment for them be on a lump sum purchase basis. Implementation of this provision was delayed until December 1989 and was superseded by OBRA 1989's directive to continue treating them as medical supplies provided within the scope of home health services. The net outcome of the OBRA 1989 provision was no change in status regarding reimbursement for ostomy supplies. They will continue to be provided under the home health services benefit, which is not subject to the 20 percent beneficiary coinsurance payment. Coinsurance payments would have been required if such supplies were treated as durable medical equipment.

OBRA 1989 also clarified the reimbursement status of parenteral and enteral nutrition equipment under the DME fee schedule. Although the law did not define them as DME, reimbursement for parenteral and enteral equipment had been made under the rental cap category. OBRA 1989 specified that payments should continue to be made under the rental cap category.

OBRA 1989 required the Comptroller General to conduct a study of the appropriate uses of DME and the appropriate criteria for making determinations of medical necessity, with particular emphasis on items such as seat-lift chairs that may be subject to abusive billing practices. The study is to include an analysis of: the appropriate use of forms in making medical necessity determinations; and procedures for identifying items of DME that should no longer be reimbursed by Medicare. The Comptroller General's report was to be delivered by April 1, 1991.

OBRA 1990

OBRA 1990 made a number of changes in DME fee schedule reimbursements, effective January 1, 1991.

National limits on fees.—Prior to OBRA 1990, fee schedule payments for all categories of DME, except customized items, were to be subjected to regional limits. The regional fees were to be based on a weighted average of local and regional payment amounts and subjected to certain upper and lower limits. Payments in 1990 were based solely on local payment amounts. Payments in 1991 and 1992 were to be transitional years before full implementation of regional fees in 1993.

OBRA 1990 repealed the requirement for regional limits and replaced them with national limits on fees. The national limits are to be phased in between 1991 and 1993. In 1991, payment is based on 67 percent of the local payment amount for the item and 33 percent of the national limited payment amount. In 1992, payment is to be based on 33 percent of the local payment amount and 67 percent of the national limited payment amount. In 1993, payment will be based solely on the national limited payment amount.

The method of determining local payment amounts is unchanged. In 1991, the upper limit on the national limited payment amount is equal to 100 percent of the weighted average of all local payment amounts for the item, and the lower limit is equal to 85 percent of the weighted average of all local payment amounts. In subsequent years, both the lower and upper limits on the national limited payment amounts are updated by the covered item increase for that year. In 1993, payment amounts will not be above the upper limit or below the lower limit.

The covered item update for 1991 and 1992 is set at minus 1 percent. For 1993 and subsequent years, the covered item update is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12 month period ending with June of the preceding year.

Removal of prosthetics and orthotics from the DME fee schedule.—Prosthetics and orthotics, formerly in the covered items other than DME category, were removed from the DME fee schedule. Payment methods for these items, established under a new section of law, remain the same as they were under the DME fee schedule, with two exceptions. First, fee schedule payments for these items were frozen in 1991. Second, regional limits on fees, which were repealed and replaced with national limits on fees for most other categories of DME, were retained for prosthetics and orthotics.

Reductions in payments for overvalued equipment.—Fee schedule payments for seat-lift chairs and transcutaneous electrical nerve stimulators (TENS) which were reduced by 15 percent in OBRA 1989, are reduced by an additional 15 percent. Payment for seat-lift chairs is limited to payment for the seat-lift mechanism only; no payment will be made for the chair itself.

"Rental cap" items.—OBRA 1990 directed that rental payments for other items of DME ("rental cap" items) be based on 10 percent of the average reasonable charges in the first 3 months, and 7.5 percent of average reasonable charges from the 4th through the 15th month. Thus, total payments are reduced from 150 to 120 per-

cent of average reasonable charges, instead of average purchase prices. Suppliers are directed to offer beneficiaries the option of purchasing items during the 10th month of continuous rental. Beneficiares must notify suppliers within 1 month of a purchase offer if they elect to purchase the item. In that case, suppliers are to transfer title of the item on the first day of the 14th month of continuous rental.

Payments for maintenance and servicing of purchased items may be made for parts and labor not covered by the supplier's or manufacturer's warranty, as determined appropriate by the Secretary for the particular type of equipment. These payments are to be established by the Secretary on the basis of reasonable charges in the locality for maintenance and servicing.

Power-driven wheelchairs are subject to different purchase conditions. Suppliers are required to offer beneficiaries an option to purchase a power-driven wheelchair at the time the item is furnished. If the beneficiary elects to purchase it, payment is made on a lump-sum basis.

Establishment of a useful lifetime.—OBRA 1990 directs the Secretary to establish a reasonable useful lifetime for two categories of equipment: other items of DME ("rental cap" items); and items requiring frequent and substantial servicing. A reasonable lifetime is defined as 5 years, except if the Secretary determines that a 5-year period is not appropriate for a particular item. In that case, the Secretary is to establish an alternative reasonable lifetime for the item.

Payment for replacement of items may take place under two conditions: (1) the reasonable lifetime of an item is reached during a period of continuous medical use; or (2) the Medicare carrier determines that an item is lost or irreparably damaged. Beneficiaries can choose whether to have payment for the replacement of an item requiring frequent and substantial servicing made either on a rental or a lump-sum purchase basis. Payment for replacement of a rental cap item is made only for rental of the item.

Wheelchairs.—OBRA 1989 moved power-driven wheelchairs from the other items of DME ("rental cap") category into the frequently purchased category of equipment and permitted treatment of these items as customized equipment, under conditions specified by the Secretary. OBRA 1990 reverses this action and returns power-driven wheelchairs to the rental cap category. OBRA 1990 also delineates the conditions under which power-driven wheelchairs are to be treated as customized items. Effective January 1, 1992, they will be treated as customized items if the wheelchair has been measured, fitted, or adapted in consideration of the patient's body size, disability, period of need or intended use, and has been assembled by a supplier or ordered from a manufacturer who offers customized features, modifications, or components for individual patients' use. If the Secretary develops criteria for treatment of customized wheelchairs prior to January 1, 1992, these guildelines will not become effective.

Administrative procedures.—The Secretary is to develop and periodically update a list of items he determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization. The list must include: seat-lift mechanisms; transcutaneous electrical nerve stimulators; and motorized scooters. Carriers are required to determine, in advance, whether payment for an item on this list will not be made because it is not medically necessary.

Suppliers are prohibited from distributing to physicians or beneficiaries any completed or partially completed forms or documents required by the Secretary. These forms, sometimes referred to as medical necessity forms, are used to document that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or needed to improve the functioning of a malformed body member. Suppliers who knowingly or willfully distribute these forms are subject to a civil money penalty not to exceed $1,000.

Parenteral and enteral nutrients, supplies and equipment.—Parenteral and enteral nutrients, suppliers and equipment are reimbursed on the basis of reasonable charges and updated by the CPI-U. OBRA 1990 prohibits updating these charges during 1991.

Oxygen and oxygen equipment.—OBRA 1990 requires that physicians treating certain patients receiving home oxygen therapy services reevaluate the continuing need for such services between 60 and 90 days of the date when these services are initiated. Patients required to undergo reevaluation include those whose initial blood gas values are at or above a partial pressure of 55 or whose arterial oxygen saturations are at or above 89 percent, or other values, pressures or criteria specified by the Secretary. No payment will be made for home oxygen therapy services after this initial 90-day period unless the attending physician certifies that a continuing medical need exists.

MEDICARE PAYMENTS FOR SERVICES IN HOSPITAL OUTPATIENT DEPARTMENTS

Medicare outpatient hospital services are reimbursed under Medicare part B. Services provided in outpatient hospital settings and included in expenditure data for this service setting are: emergency room services, clinic, laboratory, radiology, pharmacy, physical therapy, ambulance, operating room services, end stage renal disease services, durable medical equipment, and other services such as computer axial tomography and blood. Services rendered by physicians in outpatient hospital settings are not included in these expenditure data.

Prior to 1983, hospital outpatient services, excluding physicians' services, were paid for on a reasonable cost basis. Some services, such as emergency services, are still reimbursed on a reasonable cost basis. However, Congress has enacted a number of provisions that have altered the ways hospital outpatient departments are paid for their services and placed limits on others. For example, outpatient dialysis services are paid on the basis of a fixed composite rate; clinical laboratory services are paid on the basis of a fee schedule; x-ray services are subject to a limit on payments; and ambulatory surgical facility fees for surgeries performed in hospital outpatient departments are based on a weighted average of the hospital's costs and the prevailing fee that would be paid to a freestanding ambulatory surgical facility in the area.

Payments for services delivered in outpatient hospitals were $5.6 billion in calendar year 1987. Payments to outpatient hospitals constituted approximately 19 percent of all Medicare part B payments in 1986 and about 6 percent of total Medicare payments (parts A and B). Table 14 provides information on the number of part B enrollees, covered charges, aggregate reimbursements and reimbursements per enrollee for hospital outpatient services from 1974 to 1987. Table 15 shows the percent distribution of Medicare hospital outpatient charges, by type of service for 1987.

TABLE 14.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENT BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED: SELECTED YEARS 1974–87

Type of enrollment and year service	Number of SMI[1] enrollees in thousands	Covered charges in thousands	Reimbursements		
			Amount in thousands	Per enrollee	Percent of charges
All beneficiaries:					
1974	23,167	$535,296	$323,383	$14	60.4
1976	24,614	974,708	630,323	26	64.7
1978	26,074	1,384,067	923,658	35	66.7
1980	27,400	2,076,396	1,441,986	52	69.4
1982	28,412	3,164,530	2,203,260	78	69.6
1984	29,416	5,129,210	3,387,146	115	66.0
1985	29,989	6,480,777	4,082,303	136	63.0
1986	30,590	8,115,976	4,881,605	160	60.1
1987	31,170	9,623,763	5,600,094	180	58.2
	Average annual rate of growth				
1974–87	2.3	24.9	24.5	21.7	−0.3
1974–84	2.4	25.4	26.5	23.4	0.9
1984–87	1.9	23.3	18.2	16.1	−4.1
Aged:					
1974	21,422	$394,680	$220,742	$10	55.9
1976	22,446	704,569	432,971	19	61.5
1978	23,531	1,005,457	648,294	28	64.5
1980	24,680	1,517,183	1,030,896	42	69.9
1982	25,707	2,402,462	1,654,064	64	68.5
1984	26,764	4,122,859	2,679,571	100	65.0
1985	27,311	5,210,762	3,211,744	118	61.6
1986	27,863	6,529,273	3,809,992	137	58.4
1987	28,382	7,859,038	4,436,787	156	56.5
	Average annual rate of growth				
1974–87	2.2	25.9	26.0	23.5	0.1
1974–84	2.3	26.4	28.4	25.9	1.5
1984–87	2.0	24.0	18.3	16.0	−4.6
Disabled:					
1974	1,745	$140,617	$102,641	57	70.8
1976	2,168	270,139	197,352	91	73.1
1978	2,543	378,600	275,409	108	72.7
1980	2,719	559,213	411,090	152	73.5
1982	2,705	762,068	558,195	206	73.2
1984	2,651	1,006,351	707,575	267	70.3

TABLE 14.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENT BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED: SELECTED YEARS 1974–87—Continued

Type of enrollment and year service	Number of SMI [1] enrollees in thousands	Covered charges in thousands	Reimbursements		
			Amount in thousands	Per enrollee	Percent of charges
1985	2,678	1,270,015	870,560	325	68.5
1986	2,727	1,586,703	1,071,613	393	67.5
1987	2,788	1,764,726	1,163,307	417	65.9
	Average annual rate of growth				
1974–87	3.7	21.5	20.5	16.5	−0.6
1974–84	4.3	21.8	21.3	16.7	−0.1
1984–87	1.7	20.6	18.0	16.0	−2.1

[1] 1974 is the first full year of coverage for disabled beneficiaries under Medicare.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; Data developed by the Office of Research and Demonstrations.

From 1980 to 1986, hospital outpatient reimbursements grew almost 23 percent a year.[1] By comparison, part B expenditures, excluding outpatient hospitals, grew an average of 16.4 percent from fiscal 1980 to 1986, and part A payments averaged increases of 12.9 percent during the same time period.[2]

TABLE 15.—PERCENT DISTRIBUTION OF HOSPITAL OUTPATIENT CHARGES UNDER MEDICARE, BY TYPE OF SERVICE, 1987

	Percent of charges
Radiology	24.2
End stage renal disease	14.2
Laboratory	13.0
Operating room	9.7
Pharmacy	4.8
Emergency room	4.2
Clinic	2.9
Physical therapy	2.8
Ambulance	1.0
All other	23.2

Source: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System (unpublished).

---

[1] Health Care Financing Administration data based on a 5-percent sample of incurred claims for calendar 1986.

[2] Data were obtained from the Health Care Financing Administration, Division of Budget. These data are compiled on a fiscal year basis and represent cash outlays for budget expenditures. Note that these data are not obtained from the same source as those cited above, which are calendar year data based on incurred costs. Data for solely outpatient hospital incurred expenditures for calendar years are not available. Data from 1980 through 1986 are used to compare rates of growth for recent years.

Recent legislative changes

Capital.—OBRA 1989 reduced payments for capital costs for outpatient services paid on a reasonable cost basis or a blend of reasonable costs and charges by 15 percent for portions of cost-reporting periods *beginning* in fiscal year 1990. This reduction also applied to capital related to services reimbursed on a blended amount; these services include radiology, diagnostic procedures and outpatient surgery. However, in the case of blends or limits based on blends, the reduction applied only to the cost portion of the blended amount. Outpatient capital costs of sole community hospitals were exempt from this reduction.

OBRA 1990 reduced reimbursement for capital costs for outpatient hospital services and the cost portion of outpatient hospital services paid on the basis of a blended amount for payments attributable to portions of cost-reporting periods *occurring during* fiscal year 1991 by 15 percent. These payments will be reduced by 10 percent for portions of cost-reporting periods *occurring during* fiscal years 1992, 1993, 1994, and 1995. Sole community hospitals and rural primary care hospitals are exempt from these reductions.

Services paid on a cost-related basis.—OBRA 1990 also reduced payment for services paid on a cost-related basis, other than capital costs, by 5.8 percent of the recognized costs for payments attributable to cost-reporting periods occurring during fiscal years 1991, 1992, 1993, 1994, and 1995. The reduction is also applied to cost portions of blended payment limits for ambulatory surgery and radiology services. Sole community hospitals and rural primary care hospitals are exempt from the reduction.

Prospective payment proposal.—OBRA 1990 also directed the Secretary to develop a proposal to replace the current payment system for hospital outpatient services with a prospective payment system. The Secretary is to consider the following factors in developing the proposal: (1) the need to provide for appropriate limits on increases in Medicare expenditures; (2) the need to adjust prospectively determined rates to account for changes in a hospital's outpatient case mix; (3) providing hospitals with incentives to control the costs of providing outpatient services; (4) the feasibility and appropriateness of including payment for outpatient services not currently paid on a cost-related basis under Medicare (including clinical diagnostic laboratory tests and dialysis services) in the system; (5) the need to increase payments to hospitals that treat a disproportionate share of low-income patients; teaching hospitals; and hospitals located in geographic areas with high wages and wage-related costs; (6) the feasibility and appropriateness of bundling services into larger units, such as episodes or visits, in establishing the basic unit for making payments under the system; and (7) the feasibility and appropriateness of varying payments on the basis of whether services are provided in a freestanding or hospital-based facility.

The law also required the Administrator of Health Care Financing Administration to submit research findings regarding prospective payments for hospital outpatient services to specified committees of Congress by January 1, 1991. The Secretary is directed to submit his proposal to Congress by September 1, 1991. The Prospective Payment Assessment Commission (ProPAC) is to submit its analysis and comments on the proposal by March 1, 1992.

Eye and eye and ear specialty hospitals.—OBRA 1990 also changed the reimbursement blend for ambulatory surgery services provided in eye, and eye and ear specialty hospitals meeting specified conditions. Prior to OBRA 1990, the payment for these services was based on a blend that consists of 75 percent of the hospital's costs and 25 percent of the applicable freestanding ambulatory surgical center rate. However, the blend was scheduled to change to 50/50 for cost-reporting periods beginning after fiscal year 1990. OBRA 1990 extended use of the 75/25 blend to services provided in cost-reporting years beginning before January 1, 1995.

UTILIZATION AND QUALITY CONTROL PEER REVIEW PROGRAM

The Social Security Amendments of 1972 provided for the establishment of Professional Standards Review Organizations (PSRO's) throughout the country which were charged with the comprehensive and on-going review of services provided under Medicare, Medicaid, and the maternal and child health programs. PSRO's determined, for purposes of reimbursement under these programs, whether services are: (1) medically necessary, (2) provided in accordance with professional standards, and (3) in the case of institutional services, rendered in the appropriate setting.

The Tax Equity and Fiscal Responsibility Act of 1982 repealed the existing PSRO program and established a new program. Under this new program, a Peer Review Organization (PRO) is defined as an entity which is either composed of a substantial number of the licensed doctors of medicine and osteopathy practicing in the area or has available to it sufficient numbers of such physicians so that adequate peer review of various medical services can be assured.

The PRO program is similar to the PSRO program with the following important distinctions. Under the new program, eligible organizations may be either for-profit or non-profit and may be either physician groups or have available to them sufficient physicians to perform review. The Secretary is required to consolidate existing PSRO geographic areas. Each State has been designated as a single area, plus the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa (54 PRO's). The Secretary is required to enter into a contract with a peer review organization for each geographic area. Priority consideration must be given to physician-sponsored organizations; payor organizations were excluded from participation until October 1, 1984. Contracts with provider or provider-affiliated organizations are prohibited though subcontracts with such entities are permitted. As of January 1, 1985, the Secretary had entered into agreements with 53 physician-sponsored organizations and one fiscal intermediary. The law provides that contracts are for an initial period of 2 years, renewable biennially. Contracts with PRO's must specify objectives to be achieved for each PRO over the contract period. Performance will be rated in terms of meeting these goals.

These entities may review, subject to the provisions of the contracts, the professional activities of physicians, other practitioners and institutional and noninstitutional providers in rendering services to Medicare beneficiaries. The review is to focus on the necessity and reasonableness of care, quality of care, and the appropriateness of the setting. The determinations of the peer review organizations would ordinarily be binding for purposes of determining whether benefits should be paid.

States are authorized to contract with review organizations for Medicaid review and 75 percent Federal matching is authorized for such purpose.

Hospitals were required to sign an agreement with a PRO in the area on or before November 15, 1984, as a condition of receiving payment under the Medicare program.

CBO Baseline Medicare Projections

The supplementary medical insurance (SMI) baseline is constructed following the Medicare volume performance standard (the standard) guidelines established in OBRA 1989 and amended in OBRA 1990. The standard is a prospectively set target for growth in physicians' services. Actual growth is then compared to the standard and physicians' fees are adjusted to reflect the difference between the standard and actual growth. For example, the 1990 standard was set at 9.1 percent for all physicians' services. The most current estimate of actual growth in 1990 expenditures for physicians' services is 12.4 percent. If actual growth is 12.4 percent, then the 1992 Medicare Economic Index (MEI) would be reduced by the difference (3.3 percent) subject to a maximum reduction of 2 percentage points. CBO's baseline projects an update of MEI minus 2 percentage points for 1992.

For 1991, the Congress set separate standards for surgical and nonsurgical services by directing the Secretary of Health and Human Services (HHS) to calculate the growth in expenditures for each category of services without the effects of changes made by provisions in OBRA 1990, subtract the change in growth due to the changes made in OBRA 1990, and then subtract 2 percentage points. On December 28, 1990, HHS announced that the 1991 standard is 3.3 percent for surgical services, 8.6 percent for nonsurgical services, and 7.3 percent for all physicians' services.

For years after 1991, a default process was established to set a standard in the absence of congressional action. A standard is calculated for all physicians' services and for surgical and nonsurgical services separately. Surgical services are defined as surgical services performed by surgical specialists. Nonsurgical services are all other physicians' services including independent laboratory services. If the default becomes the standard, then the update for each category of physicians' services would be adjusted by the difference between growth in expenditures and the standard for each category.

The default standard is the product of (1) the increase in fees for physician services, (2) the increase in average enrollment (or non-HMO enrollees), (3) the average annual increase in the volume and intensity of services for the past 5 years, (4) the percentage increase or decrease caused by legislation or regulation, and (5) 1 minus the standard factor stated in the law. The standard factor is 1.5 percentage points in 1992 and is 2 percentage points in 1993 and thereafter. Table 16 displays CBO baseline projections of the default standard, the growth in expenditures, and the update adjustment for all physicians' services and for each category of services. CBO projects only an overall default standard for 1992-96 because of uncertainty over the effects of implementation of the physician fee schedule on the distribution of spending between surgical and nonsurgical services.

TABLE 16.—CBO PROJECTIONS OF MEDICARE VOLUME PERFORMANCE STANDARDS

[Fiscal years, in percent]

	1990	1991	1992	1993	1994	1995	1996
MVP standard overall [1]	9.1	7.3	6.2	8.0	8.2	8.6	8.6
Growth in overall expenditures	11.8	9.6	10.6	10.8	11.2	11.5	11.8
Difference	−2.7	−2.3	−4.4	−2.8	−3.0	−2.9	−3.2
Maximum allowable reduction			−2.0	−2.0	−2.5	−2.5	−3.0
MEI adjustment			−2.0	−2.0	−2.5	−2.5	−3.0
MVP standard surgical services		3.3	(2)	(2)	(2)	(2)	(2)
Growth in surgical expenditures		4.8	(2)	(2)	(2)	(2)	(2)
Difference		−1.5	(2)	(2)	(2)	(2)	(2)
Maximum allowable reduction			−2.0	−2.0	−2.5	−2.5	−3.0
MEI adjustment				−1.5	(2)	(2)	(2)
MVP standard nonsurgical services		8.6	(2)	(2)	(2)	(2)	(2)
Growth in nonsurgical expenditures		11.1	(2)	(2)	(2)	(2)	(2)
Difference		−2.5	(2)	(2)	(2)	(2)	(2)
Maximum allowable reduction			−2.0	−2.0	−2.5	−2.5	−3.0
MEI adjustment				−2.0	(2)	(2)	(2)
Projected MEI (calendar year)	4.2	4.8	3.6	2.6	3.3	3.6	3.8
Adjusted overall MEI (calendar year) [3]			1.2	.7	.8	1.1	.8

[1] The 1990 and 1991 Standards were announced by the Secretary of Health and Human Services. Standard values for 1992–96 are CBO projections.

[2] Because of uncertainty over the redistributive effects of the physician fee schedule on the categories of services, CBO projects only an overall default standard for 1992–96.

[3] The 1990 and 1991 MEI updates are not affected by the Medicare Volume Performance Standard process, however, physicians' fees for both years were reduced by other legislation. In addition to the 2.0 percentage point reduction shown here for 1992, OBRA 1990 reduced the 1992 MEI by 0.4 percentage points, so the adjusted overall MEI for 1992 is 3.6 minus 2.4, or 1.2 percent.

TABLE 17.—CBO BASELINE PROJECTIONS FOR MEDICARE PROGRAM COMPONENTS

[Outlays by fiscal year, in billions of dollars]

	1990	1991	1992	1993	1994	1995	1996
I. Part A. Hospital Insurance [HI]							
A. Total HI outlays	66.7	70.1	77.7	84.5	93.2	102.7	113.2
Hospitals	56.8	59.5	65.6	71.2	78.2	86.0	94.6
PPS hospitals	(51.9)	(53.8)	(59.2)	(63.9)	(69.9)	(76.5)	(83.8)
PPS-exempt hospitals	(4.9)	(5.7)	(6.5)	(7.3)	(8.3)	(9.5)	(10.8)
HMO's	2.4	2.8	3.3	3.9	4.7	5.6	6.7
Hospice	.4	.5	.6	.7	.9	1.0	1.1
Home health	3.1	3.5	3.9	4.3	4.7	5.1	5.5
Skilled nursing facilities [1]	2.5	2.4	2.6	2.8	3.1	3.3	3.6
Other part A	.6	.2	.3	.2	.3	.2	.2
Administration (subject to appropriations)	.8	1.1	1.2	1.3	1.3	1.4	1.5
B. General part A Information:							
Indirect teaching payments	2.7	2.9	3.1	3.3	3.7	4.0	4.4
Direct medical education payments	1.3	1.3	1.3	1.3	1.3	1.4	1.5
Disproportionate share payments	1.6	2.2	2.3	2.5	2.8	3.0	3.3
Inpatient capital payments	6.1	6.6	7.6	8.4	9.3	10.2	12.2
Beneficiary copayments	4.4	5.7	6.2	6.6	7.2	7.8	8.6
HI deductible (in calendar year dollars)	592	628	652	680	720	764	816
Part A fiscal year enrollment (in millions)	33.1	33.7	34.4	34.9	35.4	35.9	36.5
PPS market basket increase (in fiscal year percent)	5.5	5.2	4.0	4.5	4.7	4.7	4.6
Monthly premium (in calendar year dollars)	175	177	193	207	225	245	267
Premium receipts	.1	.2	.4	.5	.6	.6	.7
II. Part B Supplementary Medical Insurance [SMI]							
A. Total SMI outlays	43.0	46.4	52.1	58.6	65.8	74.2	84.0
Physicians	26.4	28.5	31.3	34.5	38.0	42.0	46.6
DME suppliers	1.5	1.6	1.8	2.0	2.2	2.4	2.7
Laboratories (independent) [2]	1.5	1.7	2.0	2.4	3.0	3.7	4.6
Outpatient hospital	8.3	9.0	10.3	12.1	14.2	16.7	19.5

TABLE 17.—CBO BASELINE PROJECTIONS FOR MEDICARE PROGRAM COMPONENTS—Continued

[Outlays by fiscal year, in billions of dollars]

	1990	1991	1992	1993	1994	1995	1996
Group practice plans and HMOs	2.6	3.0	3.5	4.1	4.8	5.6	6.6
Other part B	1.3	1.2	1.6	1.9	1.8	1.9	2.1
Administration (subject to appropriation)	1.5	1.4	1.5	1.6	1.7	1.8	1.9
B. General part B information:							
SMI deductible (in dollars)	75	100	100	100	100	100	100
MEI update (calendar year in percent)	4.2	4.8	3.6	2.6	3.3	3.6	3.8
Laboratory update (calendar year)	4.7	2.0	2.0	2.0	3.6	3.6	3.6
DME update (calendar year)	0.0	4.2	2.5	3.6	3.6	3.6	3.7
C. Premium information:							
Monthly premium (in dollars)	28.60	29.90	31.80	36.60	41.10	46.10	47.80
Premium receipts	11.6	11.6	12.5	14.3	16.3	18.5	19.8
Enrollment (in millions)	32.3	32.7	33.1	33.5	34.0	34.4	34.8
Total Medicare disbursements	109.7	116.5	129.8	143.1	158.9	176.9	197.2
Total Medicare (disbursements net of premiums)	97.9	104.7	116.9	128.3	142.1	157.7	176.7

---

[1] Spending on skilled nursing facility (SNF) services declines in 1991 because of the repeal of the Medicare Catastrophic Coverage Act of 1988, which expanded SNF benefits.

[2] Laboratory services are also provided by physicians and outpatient hospitals. Spending for these services is included in the appropriate provider category.

Source: CBO February Baseline.

MEDICARE AS SECONDARY PAYER

Under current law, Medicare is a secondary payer under specified circumstances when beneficiaries are covered by other third-party payers. Medicare is secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurance.

Medicare is also secondary payer to certain employer health plans covering aged and disabled beneficiaries and for end stage renal disease (ESRD) beneficiaries during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

Table 18 shows savings attributable to these Medicare secondary payer provisions. In fiscal year 1985, combined Medicare part A and part B savings were $756 million. By fiscal year 1990, the total savings equaled $2.5 billion.

TABLE 18.—MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS BY TYPE OF CIRCUMSTANCE

[In millions, by fiscal year]

	Workers compensation	Working aged	ESRD	Automobile	Disability	Total
1985: [1]						
Part A	$132.4	$318.1	0	$156.7	0	$607.2
Part B	18.8	110.8	0	13.6	0	143.2
Total	151.2	428.9	0	170.3	0	750.4
1986:						
Part A	136.9	521.1	$83.6	158.3	0	899.9
Part B	13.8	191.0	11.7	19.4	0	235.9
Total	150.7	712.1	95.3	177.7	0	1,135.8
1987:						
Part A	117.5	647.3	86.6	161.5	$117.0	1,129.9
Part B	19.4	248.9	16.3	23.9	13.9	322.4
Total	136.9	896.2	102.9	185.4	130.9	1,452.3
1988:						
Part A	110.1	786.7	88.4	149.6	275.5	1,410.3
Part B	18.1	313.8	20.2	22.3	93.5	467.9
Total	128.2	1,100.5	108.6	171.9	369.0	1,878.2
1989:						
Part A	99.4	867.7	75.0	179.6	399.3	1,621.0
Part B	27.5	337.1	25.1	28.2	137.0	554.9
Total	126.9	1,204.8	100.1	207.8	536.3	2,175.9
1990:						
Part A	120.9	981.6	144.1	220.1	498.4	1,965.1
Part B	21.6	325.8	21.5	26.4	123.2	518.5
Total	142.5	1,307.4	165.6	246.5	621.6	2,483.6

[1] Savings from workers compensation and ESRD were combined under workers compensation in 1985.

[2] Medicare secondary to disability insurance benefits was effective January 1, 1987.

Source: Health Care Financing Administration

FINANCING

Background

The Medicare part A Hospital Insurance Trust Fund (HI) finances inpatient hospital, skilled nursing facility, home health and other institutional services. The part B Supplementary Medical Insurance Trust Fund (SMI) finances principally physician and hospital outpatient services.

The Hospital Insurance Trust Fund is financed primarily through Social Security payroll tax contributions paid by employers, employees and the self-employed. The payroll tax rate for HI for calendar year 1991 is 1.45 percent up to $125,000 in earnings. The OASDI earnings base for 1991 is $53,400 per employee. An equal contribution rate is paid by the employer. Table 19 shows the contribution rates and maximum taxable earnings for both HI and the old-age, survivors and disability insurance (OASDI) programs.

TABLE 19.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR EMPLOYERS AND EMPLOYEES EACH AND TAXABLE EARNINGS BASES

Calendar year	Employee and employer rates, each (percent)			Taxable earnings base	Maximum HI tax
	OASDI combined	HI	OASDHI combined		
1977	4.95	0.90	5.85	$16,500	$148.50
1978	5.05	1.10	6.05	17,700	194.70
1979	5.08	1.05	6.13	22,900	240.45
1980	5.08	1.05	6.13	25,900	271.95
1981	5.35	1.30	6.65	29,700	386.10
1982	5.40	1.30	6.70	32,400	421.20
1983	5.40	1.30	6.70	35,700	464.10
1984	5.70	1.30	7.00	37,800	491.40
1985	5.70	1.35	7.05	39,600	534.60
1986	5.70	1.45	7.15	42,000	609.00
1987	5.70	1.45	7.15	43,800	635.10
1988	6.06	1.45	7.51	45,000	652.50
1989	6.06	1.45	7.51	48,000	696.00
1990	6.20	1.45	7.65	51,300	743.85
1991	6.20	1.45	7.65	[1] 125,000	1,812.5
1992 and after	6.20	1.45	7.65	(2)	(2)

[1] The Omnibus Budget Reconciliation Act of 1990 created a separate tabable earnings base for HI. Prior to 1991, the OASDI and HI bases were the same. In 1991, the OASDI base is $53,400.

[2] The maximum earnings subject to the tax increases each year in accordance with the increase in average earnings.

As table 20 demonstrates, the bulk of the financing for HI is derived from payroll taxes. In 1990, there will be transferred an estimated $332 million from the railroad retirement fund. This is the estimated amount that would have been in the fund if railroad employment had always been covered under the Social Security Act.

HI benefits are provided to certain uninsured persons who became 72 before 1968. Such payments are made initially from the

HI Trust Fund, with reimbursement from the general fund of the Treasury for the costs, including administrative expenses, of the payments. Approximately $413 million will be transferred to HI during 1990 on this basis.

Certain persons not eligible for HI protection either on an insured basis or on the uninsured basis described in the previous paragraph may obtain protection by enrolling in the program and paying a monthly premium ($177 in 1991). This accounts for $113 million of financing in fiscal year 1990.

Sections 217(g) and 229(b) of the Social Security Act, prior to modification by the Social Security Amendments of 1983, authorized annual reimbursement from the general fund of the Treasury to the HI Trust Fund for costs arising from the granting of deemed wage credits for military service prior to 1957, according to quinquennial determinations made by the Secretary of Health and Human Services. These sections, as modified by the Social Security Amendments of 1983, provided for a lump sum transfer in 1983 for costs arising from such wage credits. In addition, the lump sum transfer included combined employer-employee HI taxes on the noncontributory wage credits for military service after 1965 and before 1984. After 1983, HI taxes on military wage credits are credited to the fund on July 1 of each year. The Social Security Amendments of 1983 also provided for (1) quinquennial adjustments to the lump sum amount transferred in 1983 for costs arising from pre-1957 deemed wage credits and (2) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on noncontributory wage credits. In 1989, this accounts for $107 million of income to the HI trust fund.

The remaining $7,943 million of receipts consisted almost entirely of interest on the investments of the trust fund and interest on interfund borrowing.

TABLE 20.—INCOME TO THE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS FOR SELECTED FISCAL YEARS

[Dollars in millions]

	Fiscal year								Percent of total 1992 financing
	1970 [1]	1975 [1]	1980	1985	1990	1991 [2]	1992 [2]	1995 [2]	
Hospital insurance:									
Payroll taxes	$4,785	$11,291	$23,244	$46,490	$70,655	$75,921	$84,047	$102,895	57.7
Transfers from railroad retirement account	64	132	244	371	332	330	338	363	.2
Reimbursement for uninsured persons	617	481	697	766	413	605	621	256	.4
Premiums from voluntary enrollees [3]	0	6	17	38	113	197	411	613	.3
Payments for military wage credits	11	48	141	86	107	89	88	89	.1
Interest on investments and other income	137	609	1,072	3,182	7,943	8,770	9,925	13,489	6.8
Total	5,614	12,568	25,415	50,933	79,563	85,912	95,430	117,705	65.5
Supplementary medical insurance:									
Premiums	936	1,887	2,928	5,524	11,133	11,617	12,459	18,517	8.6
General revenues	928	2,330	6,932	17,898	33,210	34,370	36,537	54,242	25.1
Interest and other income	12	105	415	1,155	1,412	1,282	1,238	1,016	.8
SMI catastrophic premiums					361	0	0	0	0
Supplemental catastrophic premium refund					−566	0	0	0	0
Total	1,876	4,322	10,275	24,577	45,550	47,269	50,234	73,775	34.5
Grand total	7,490	16,890	35,690	75,510	125,113	133,181	145,664	191,480	100.0

[1] For fiscal years 1970 and 1975, the interval is from July 1 to June 30.

[2] Based upon CBO economic assumptions.

[3] Medicaid payment of Medicare premiums is required on behalf of certain under-poverty persons on Medicaid, and over 65 years of age but not eligible for Medicare, effective January 1, 1989 according to Medicare Catastrophic Coverage Act of 1988.

Source: 1988 Annual Reports of the Board of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds and Congressional Budget Office for 1990–95 projections.

Part B, which is voluntary, is financed from premiums paid by the aged, disabled and chronic renal disease enrollees and from the general revenues. The premium rate is derived annually based upon the projected costs of the program for the coming year. Under prior law, the premium rate was changed on July 1 of each year. The Social Security Amendments of 1983 (Public Law 98-21) moved the premium increase date to January 1 of each year to coincide with the changed date for the annual Social Security cash benefit cost-of-living (COLA) increase.

Ordinarily, the premium rate is the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the COLA provisions of the Social Security program. Premium income, which originally financed half of the costs of part B, has declined—as a result of this formula—to less than 25 percent of total program income.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), temporarily suspended the COLA limitation for 2 years—calendar years 1984 and 1985. During this period, enrollee premiums were allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The Deficit Reduction Act of 1984 (Public Law 98-369) extended the TEFRA provision through calendar years 1986 and 1987. The 1987 reconciliation bill (Public Law 100-203) extended the provision through 1989 and the 1989 reconciliation bill extended the provision through 1990. The Omnibus Reconciliation Act of 1990 set the premium rates in law for the 1991-95 period. These premium rates are equal to 25 percent of program costs for these years. The flat premium for 1991 is $29.90 per month.

FINANCIAL STATUS OF THE TRUST FUNDS

The Hospital Insurance Trust Fund balances are dependent upon the income to the HI trust fund primarily through payroll taxes exceeding the outlays for Medicare benefits and administrative costs. Outlays are affected by increases in inpatient hospital expenditures which have been rising at a faster rate than the income to the HI trust fund. Table 21 shows the percentage increase in Medicare outlays from fiscal year 1967 to fiscal year 1990 and the Congressional Budget Office (CBO) and HCFA projections from 1991 to 1996.

TABLE 21.—MEDICARE OUTLAYS, FISCAL YEARS 1967-96

	Part A [1]		Part B		Total	
	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)
1967	2,597		799		3,396	
1968	3,815	46.9	1,532	91.7	5,347	57.4
1969	4,758	24.7	1,840	20.1	6,598	23.4
1970	4,953	4.1	2,196	19.3	7,149	8.4

TABLE 21.—MEDICARE OUTLAYS, FISCAL YEARS 1967–96—Continued

	Part A [1]		Part B		Total	
	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)
1971	5,592	12.9	2,283	4.0	7,875	10.2
1972	6,276	12.2	2,544	11.4	8,820	12.0
1973	6,842	9.0	2,637	3.7	9,479	7.5
1974	8,065	17.9	3,283	24.5	11,348	19.7
1975	10,612	31.6	4,170	27.0	14,782	30.3
1976 [2]	12,579	18.5	5,200	24.7	17,779	20.3
1977	15,207	20.9	6,342	22.0	21,549	21.2
1978	17,862	17.5	7,356	16.0	25,218	17.0
1979	20,343	13.9	8,814	19.8	29,157	15.6
1980	24,288	19.4	10,737	21.8	35,025	20.1
1981	29,260	20.5	13,228	23.2	42,488	21.3
1982	34,864	19.2	15,560	17.6	50,424	18.7
1983	38,624	10.8	18,311	17.7	56,935	12.9
1984	42,108	9.0	20,372	11.3	62,480	9.7
1985	48,654	15.5	22,730	11.6	71,384	14.3
1986	49,685	2.1	26,218	15.3	75,903	6.3
1987	50,803	2.3	30,837	17.6	81,640	7.6
1988	52,730	3.8	34,947	13.3	87,677	7.4
1989	58,238	10.4	38,317	9.6	96,555	10.1
1990	66,687	14.5	43,022	12.6	109,709	13.6
CBO projections [3]						
1991 [4]	70,109	5.1	46,417	7.9	116,526	6.2
1992	77,698	10.8	52,073	12.2	129,771	11.4
1993	84,456	8.7	58,636	12.6	143,092	10.3
1994	93,168	10.3	65,779	12.2	158,947	11.1
1995	102,659	10.2	74,201	12.8	176,860	11.3
1996	113,233	10.3	83,955	13.1	197,188	11.5
HCFA projections [3]						
1991 [4]	70,211	5.3	46,056	7.1	116,267	6.6
1992	77,583	10.5	52,116	13.2	129,698	11.6
1993	84,506	8.9	59,134	13.5	143,640	10.7
1994	93,441	10.6	67,325	13.9	160,766	11.9
1995	103,119	10.4	76,800	14.1	179,919	11.9
1996	114,575	11.1	87,529	14.0	202,104	12.3

---

[1] Includes catastrophic outlays beginning in fiscal year 1989. There will be no catastrophic outlays after fiscal year 1990.

[2] In the transition quarter from July to October 1976 (when the beginning of the Federal fiscal year was changed), outlays were $4,805 million. These outlays do not appear in the table.

[3] Projections under current law.

[4] Includes payment cycle shift which shifts outlays from 1991 to 1990.

Source: 1990 Annual Report of the Board of Trustees: HI Trust Fund and SMI Trust Fund, HCFA Office of the Actuary, for 1990–1996, HCFA Division of Budget, and CBO.

Supplementary medical insurance

Because the Supplementary Medical Insurance (SMI) Trust Fund is financed through beneficiary premiums and the general revenues, it does not face the prospect of depletion as does the HI trust fund. However, the rapidly rising cost of health care is placing a heavy burden on the SMI trust fund—causing beneficiary premiums to rise and increasing the Federal deficit.

HI trust fund income, outlays, and balance

Table 22 shows the projections of the Congressional Budget Office and the administration for the HI trust funds with respect to income, outlays and balances for the years 1990 through 1996.

TABLE 22.—PROJECTIONS FOR THE HOSPITAL INSURANCE TRUST FUND OF BUDGET AUTHORITY AND OUTLAYS, FISCAL YEARS 1990–96 UNDER CBO AND ADMINISTRATION BASELINE ASSUMPTIONS, PRESENT LAW

[By fiscal year, in billions of dollars]

	1990 [1]	1991	1992	1993	1994	1995	1996
CBO baseline, Hospital Insurance Trust Fund:							
Total outlays	66.7	[5] 71.2	77.7	84.5	93.2	102.7	113.2
Income [2]	79.6	85.9	95.4	103.1	110.3	117.7	125.3
End-of-year balance [3, 4]	96.2	111.0	128.7	147.3	164.4	179.5	191.5
Start-of-year balance, as percent of outlays	124	135	143	152	158	160	159
Administration, Hospital Insurance Trust Fund:							
Total outlays	66.7	70.2	77.6	84.5	93.4	103.1	114.6
Income [2]	79.6	86.3	95.4	103.3	111.2	118.6	126.6
End-of-year balance [3, 4]	95.6	110.6	128.4	147.2	164.9	180.4	192.5
Start-of-year balance, as percent of outlays	124	136	143	152	157	160	157

[1] Actuals.

[2] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers.

[3] Does not include Catastrophic Coverage Reserve Fund income.

[4] Fiscal year 1991 end-of-year balance reflects transfer to Treasury of $1.1 billion Military Service Credit quinquennial adjustment.

[5] CBO estimate for outlays also includes the quinquennial adjustment.

Note: Totals may not add due to rounding.

Source: Congressional Budget Office and HCFA, Division of Budget.

Sensitivity of HI trust funds balances to different outlay growth assumptions

Table 23 presents alternative projections of Hospital Insurance (HI) trust fund outlay growth through 1996. All of these projections assume the economic projections underlying the baseline path. The alternatives all are arranged in the table from least to most growth. Hospital outlays are projected to grow by 1 or 2 percent less and 1 or 2 percent more than the baseline in each year. These changes could be due to variations in hospital rate increases, admission patterns, intensity or change in case mix, or technology changes. The percentage refers to entire hospital outlays and not just those outlays covered by the prospective payment system.

Income to the trust fund is the same (except for interest which varies by size of trust fund balance) in each projection. Under the least growth alternative, expenditures are $100 billion in fiscal year 1996 compared to $124 billion in the baseline projection. Trust fund balances are $44 billion greater in this alternative.

Conversely, under the alternative with the most growth, expenditures are $11 billion higher and trust fund balances are $41 billion smaller in 1996 as compared to the baseline projection.

TABLE 23.—ALTERNATIVE PROJECTIONS OF HOSPITAL INSURANCE OUTLAY GROWTH AND YEAR-END BALANCES [1]

[By fiscal year, in billions of dollars]

	1990 [2]	1991	1992	1993	1994	1995	1996
2 percent lower HI outlay growth:							
Outlays	66.7	69.9	74.8	79.9	86.5	93.0	100.0
End-of-year balance	96.2	112.3	133.1	156.8	181.4	207.6	235.3
1 percent HI lower outlay growth:							
Outlays	66.7	70.5	76.3	82.1	89.8	97.4	105.7
End-of-year balance	96.2	111.6	130.9	152.1	173.0	194.0	214.8
Baseline:							
Outlays	66.7	71.2	77.7	84.5	93.2	102.7	113.2
End-of-year balance	96.2	111.0	128.7	147.3	164.4	179.5	191.5
1 percent higher HI outlay growth:							
Outlays	66.7	71.9	79.1	86.8	96.6	106.8	118.0
End-of-year balance	96.2	110.3	126.5	142.5	155.7	165.9	172.2
2 percent higher HI outlay growth:							
Outlays	66.7	72.5	80.6	89.2	100.2	111.7	124.6
End-of-year balance	96.2	109.6	124.2	137.7	146.8	151.4	150.0

[1] Projections for fiscal years 1991 through 1996 assume economic assumptions used in CBO baseline.

[2] Actuals.

Projections beyond 1996

Longer-term projections of trust fund balances depend on many different assumptions. Factors such as changes in PPS rates, number of beneficiaries, admission rates, and others will affect trust fund outlays. Also, the extent to which the complexity of diagnosis has grown and might continue to grow would increase outlays, but by how much is difficult to estimate. Finally, forecasting changes in medical technology and their implications for spending is very difficult.

In the absence of CBO projections beyond 1996, committee staff extrapolated the latest CBO projections from 1996 to 2015. This extrapolation was done by assuming that the average rate of growth in outlays for the last 2 years of CBO's baseline projections would remain the same through 2015. A similar assumption was made with respect to income. These results are shown in table 24.

The projections in table 24 indicate that insolvency of the HI trust fund is postponed until 2006. Compared to last year's projections, trust fund exhaustion is one year earlier. Under these com-

mittee staff extrapolations of CBO projections, the HI fund is exhausted in 2006 under the baseline path; 2003 under a 1 percent higher outlay growth rate than assumed in the baseline path; and after 2013 under a 1 percent lower growth rate in outlays relative to the baseline.

TABLE 24.—PROJECTIONS OF HI OUTLAY AND TRUST FUND BALANCES TO FISCAL YEAR 2015 BASED UPON CBO'S FEBRUARY 1991 PROJECTIONS [1]

[By fiscal year, in billions of dollars]

Fiscal year	Baseline path		Baseline path, assuming 1 percent lower annual growth		Baseline path, assuming 1 percent higher annual growth	
	Outlays	Yearend balance	Outlays	Yearend balance	Outlays	Yearend balance
February, 1991, Estimates						
1990 [2]	67	96	67	96	67	96
1995	103	180	97	194	166	166
2000	164	200	147	289	176	135
2005	264	18	220	326	290	(195)
2010	438	(700)	332	194	478	(1,229)
2015	757	(2,738)	499	(325)	788	(3,765)
Year Trust Fund exhausted		2006		2013		2003

[1] Projections for fiscal years 1991 through 1996 assume economic assumptions used in CBO baseline. Projections for fiscal years 1997–2015 are made by committee staff using the average of the growth rates for outlays and revenues in the last two years of CBO's baseline estimate. Outlay growth rates were further adjusted for changes in projected part A enrollment.

[2] Actuals.

Long-range estimates

Long-range estimates for the next 75 years are shown in table 25 for the HI program under several alternative assumptions in the 1990 HI Trustees' report. As in the case of the OASDI program, annual expenditures are expressed as a percentage of taxable earnings. The income rate is simply the combined scheduled HI tax rate for employees and employers.

The average deficit over the next 25-year period is 0.79 percent of taxable earnings under alternative II–B assumptions. With the passage of the 1990 reconciliation bill, the deficit over the next 25-year period has declined to 0.74 percent of taxable earnings.

TABLE 25.—ACTUARIAL BALANCES OF THE HOSPITAL INSURANCE PROGRAM, UNDER ALTERNATIVE SETS OF ASSUMPTIONS

[In percent]

	Alternative			
	I	II–A	II–B	III
1990–2014:				
Average contribution rate [1]	2.90	2.90	2.90	2.90
Average program expenditures [2]	2.90	3.50	3.69	4.80
Actuarial balance [3]	0.00	−0.60	−0.79	−1.90
1990–2039:				
Average contribution rate [1]	2.90	2.90	2.90	2.90
Average program expenditures [2]	3.35	4.90	5.25	8.85
Actuarial balance [3]	−0.45	−2.00	−2.35	−5.95
1990–2064:				
Average contribution rate [1]	2.90	2.90	2.90	2.90
Average program expenditures [2]	3.65	5.73	6.16	11.26
Actuarial balance [3]	−0.75	−2.83	−3.26	−8.36
Year in which trust fund is exhausted	2018	2005	2003	1999

[1] As scheduled under present law.

[2] Expenditures for benefit payments and administrative costs for insured beneficiaries, on an incurred basis, expressed as a percentage of taxable payroll, computed on the level-financing basis.

[3] Difference between the average contribution rate (tax rate scheduled in the law) and program expenditures.

Source: Tables 12 and III in the 1990 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.

MEDICARE HISTORICAL DATA

Tables 26 through 40 present detailed historical data on the Medicare program. Tables 26 through 28 present detailed enrollment data. Table 29 describes the percentage of Medicare enrollees participating in a State buy-in agreement. Tables 30 and 31 show the distribution of Medicare payments by type of coverage and type of service. Tables 32 and 33 show the number of persons served and average reimbursement amounts per person and per enrollee. Tables 34–38 present the use of inpatient hospital services, skilled nursing facility services, home health agency services and beneficiaries under the ESRD program. Table 39 presents Medicare utilization and reimbursement by State and table 40 shows the number of Medicare enrollees in prepaid health plans.

TABLE 26.—NUMBER OF MEDICARE ENROLLEES, BY TYPE OF COVERAGE AND TYPE OF ENTITLEMENT, FOR SELECTED YEARS

Type of entitlement and coverage	Number of Medicare enrollees as of July 1—												Average annual percent growth rate		
	1968	1975	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1968–75	1975–81	1981–89
Total:															
HI [1] and/or SMI [2]	19,821	24,959	28,478	29,010	29,494	30,026	30,456	31,083	31,750	32,411	32,980	33,579	3.3	2.5	1.8
Total HI	19,770	24,640	28,067	28,590	29,069	29,587	29,996	30,589	31,216	31,853	32,413	33,040	3.2	2.5	1.8
HI only	1,016	1,054	1,079	1,069	1,082	1,052	1,040	1,094	1,160	1,241	1,363	1,481	.5	.2	4.2
Total SMI	18,805	23,905	27,400	27,941	28,412	28,975	29,416	29,989	30,590	31,170	31,617	32,099	3.5	2.6	1.7
SMI only	51	318	411	420	425	439	460	493	534	558	567	539	29.8	4.8	3.2
Aged:															
HI and/or SMI	19,821	22,790	25,515	26,011	26,540	27,109	27,571	28,176	28,791	29,380	29,879	30,409	2.0	2.2	2.0
Total HI	19,770	22,472	25,104	25,591	26,115	26,670	27,112	27,683	28,257	28,822	29,312	29,869	1.8	2.2	2.0
HI only	1,016	845	835	829	833	816	807	865	928	998	1,098	1,192	−2.6	−.3	4.6
Total SMI	18,805	21,945	24,680	25,182	25,707	26,292	26,765	27,311	27,863	28,382	28,780	29,216	2.2	2.3	1.9
SMI only	51	318	411	420	425	439	459	493	534	558	557	539	29.8	4.8	3.2
All disabled: [3]															
HI and/or SMI	(4)	2,168	2,963	2,999	2,954	2,918	2,884	2,907	2,959	3,031	3,102	3,171	....	5.6	0.7
Total HI	(4)	2,168	2,963	2,999	2,954	2,918	2,884	2,907	2,959	3,031	3,101	3,171	....	5.6	0.7
HI only	(4)	209	244	239	249	235	233	229	232	243	265	288	....	2.3	2.4
Total SMI	(4)	1,959	2,719	2,759	2,705	2,682	2,651	2,678	2,727	2,788	2,837	2,883	....	5.9	0.6
End-State renal disease only: [3]															
HI and/or SMI	(4)	13	28	27	27	28	30	31	39	47	53	58	....	13.3	10.0
Total HI	(4)	13	28	27	27	28	30	31	39	47	53	58	....	13.3	10.0
HI only	(4)	1	1	1	2	2	2	2	3	3	4	5	....	13.7	22.3
Total SMI	(4)	12	27	26	26	26	28	29	36	44	49	54	....	13.3	9.6

---

[1] Hospital insurance. [2] Supplementary medical insurance. [3] Disabled and ESRD only must have HI to be eligible for SMI coverage. [4] Medicare disability entitlement began in 1973.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, "Annual Program Statistics" and unpublished data.

TABLE 27.—GROWTH IN NUMBER OF AGED MEDICARE ENROLLEES, BY SEX AND AGE, FOR SELECTED YEARS

Sex and age	Number of enrollees (in thousands)							Average annual percent growth rate			Total aged population 1989 [1]	Enrollees as percent of total aged population 1989
	1968 [1]	1975 [1]	1981	1984	1987	1988	1989	1968–75	1975–81	1981–89		
All persons	19,496	22,548	26,011	27,571	29,380	29,879	30,409	2.1	2.4	2.1	30,985	98.1
65 to 69	6,551	7,642	8,570	8,784	9,358	9,469	9,659	2.2	1.9	1.5	10,170	95.0
70 to 74	5,458	5,950	6,888	7,300	7,647	7,752	7,775	1.2	2.5	1.8	8,012	97.0
75 to 79	3,935	4,313	4,931	5,327	5,692	5,792	5,931	1.3	2.3	2.4	6,033	98.3
80 to 84	2,249	2,793	3,112	3,382	3,659	3,764	3,856	3.1	1.8	2.7	3,728	103.4
85 and over	1,303	1,850	2,510	2,778	3,024	3,102	3,187	5.1	5.2	3.2	3,042	104.8
Males	8,177	9,201	10,454	11,044	11,762	11,967	12,187	1.7	2.2	2.0	16,100	75.7
65 to 69	2,944	3,420	3,843	3,942	4,196	4,245	4,331	2.2	2.0	1.5	4,631	93.5
70 to 74	2,322	2,504	2,898	3,088	3,255	3,308	3,323	1.1	2.5	2.0	4,549	73.0
75 to 79	1,596	1,669	1,903	2,061	2,211	2,257	2,321	.6	2.2	2.5	3,648	63.6
80 to 84	864	1,005	1,068	1,161	1,257	1,296	1,330	2.2	1.0	2.7	2,422	54.9
85 and over	450	604	741	793	843	861	881	4.3	3.5	2.2	850	103.6
Females	11,319	13,347	15,557	16,526	17,619	17,912	18,222	2.4	2.6	2.1	18,349	99.3
65 to 69	3,606	4,222	4,727	4,842	5,162	5,224	5,328	2.3	1.9	1.4	5,539	96.2
70 to 74	3,136	3,446	3,990	4,212	4,393	4,444	4,452	1.4	2.5	1.6	4,549	97.9
75 to 79	2,338	2,644	3,028	3,266	3,481	3,534	3,610	1.8	2.3	2.4	3,648	99.0
80 to 84	1,386	1,788	2,043	2,222	2,402	2,468	2,526	3.7	2.2	2.7	2,422	104.3
85 and over	853	1,246	1,769	1,985	2,181	2,241	2,306	5.6	6.0	3.6	2,192	105.2

[1] Medicare enrollment for 1968 and 1975 and total aged population data is for the United States.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data; and U.S. Department of Commerce, Bureau of the Census.

TABLE 28.—GROWTH IN NUMBER OF DISABLED MEDICARE ENROLLEES WITH HI COVERAGE, BY TYPE OF ENTITLEMENT AND AGE, FOR SELECTED YEARS

Type of entitlement and age	Number of enrollees					Average annual percent growth rate		
	1975	1981	1984	1988	1989	1975–81	1981–84	1984–89
All disabled persons	2,058,424	2,998,949	2,884,410	3,101,482	3,170,917	6.5	−1.3	1.5
Under age 35	238,070	383,503	388,240	471,129	478,422	8.3	.4	3.9
35 to 44	251,142	385,139	422,207	572,408	609,974	7.4	3.1	6.3
45 to 54	508,345	654,700	584,214	670,131	705,616	4.3	−3.7	2.8
55 to 64	1,060,967	1,575,607	1,489,749	1,397,814	1,376,905	6.8	−1.9	−1.3
Disabled workers	1,638,662	2,439,446	2,309,866	2,456,135	2,510,319	6.9	−1.8	1.2
Under age 35	100,439	195,000	193,094	249,291	253,918	11.7	−.3	5.2
35 to 44	164,439	269,765	290,395	414,749	445,291	8.6	2.5	7.4
45 to 54	426,451	558,519	485,378	552,442	581,969	4.6	−4.6	2.6
55 to 64	947,333	1,416,162	1,340,999	1,239,653	1,229,141	6.9	−1.8	−1.6
Adults disabled as children	324,864	427,513	459,620	519,009	531,445	4.7	2.4	2.5
Under age 35	153,708	180,167	186,003	207,331	209,017	2.7	1.1	2.2
35 to 44	84,508	110,617	126,252	146,460	152,197	4.6	4.5	3.0
45 to 54	71,484	83,135	87,380	99,444	103,777	2.5	1.7	2.6
55 to 64	45,164	53,594	59,985	65,774	66,454	2.9	3.8	1.9
Widows and widowers	83,771	105,091	85,227	73,101	70,688	3.9	−6.7	−3.0
Under age 35	1							
35 to 44	NA	1						
45 to 54	7,445	6,523	4,608	5,685	5,658	−2.2	−10.9	4.3
55 to 64	76,325	98,567	80,618	67,416	65,030	4.4	−6.5	−3.5
End-stage renal disease only	11,127	26,899	29,697	53,237	58,465	15.8	3.4	12.4
Under age 35	3,729	8,336	9,143	14,507	10,368	14.3	3.1	9.7
35 to 44	2,187	4,756	5,559	11,199	12,486	13.8	5.3	15.0
45 to 54	2,966	6,523	6,848	12,560	14,212	14.0	1.6	12.9
55 to 64	2,245	7,284	8,147	14,971	16,280	21.7	3.8	12.9

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data.

TABLE 29.—MEDICARE ENROLLMENT: NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE (SMI) UNDER BUY-IN AGREEMENTS, BY TYPE OF BENEFICIARY AND BY YEAR OR 1989 AREA OF RESIDENCE

Year or area of residence [1]	All persons		Aged		Disabled	
	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled
Year:						
1968	1,648	8.8	1,648	8.8	NA	NA
1975	2,846	12.0	2,483	11.4	363	18.7
1980	2,954	10.9	2,449	10.0	504	18.9
1981	3,257	11.7	2,659	10.6	598	21.7
1982	2,791	9.8	2,288	8.9	503	18.6
1983	2,654	9.3	2,177	8.4	477	18.1
1984	2,601	8.9	2,127	8.0	474	18.2
1985	2,670	9.0	2,164	8.0	505	19.2
1986	2,776	9.2	2,222	8.0	554	20.9
1987	2,985	9.6	2,237	8.2	648	23.2
1988	3,033	9.6	2,341	8.1	691	24.4
1989	3,351	10.4	2,549	8.7	802	27.8
Area of residence [1]						
All areas	3,351	10.4	2,549	8.7	802	27.8
United States	3,349	10.5	2,547	8.8	802	28.3
Alabama	96	17.3	77	15.8	19	27.9
Alaska	4	17.0	3	14.6	1	32.7
Arizona	25	5.4	19	4.4	6	16.2
Arkansas	63	16.8	51	15.4	12	27.9
California	613	19.8	473	16.7	140	53.0
Colorado	35	10.7	28	9.1	8	26.2
Connecticut	22	4.9	14	3.4	8	27.6
Delaware	4	4.7	3	3.4	1	18.7
District of Columbia	13	18.4	11	16.0	3	45.3
Florida	176	7.9	144	6.9	32	21.5
Georgia	122	17.6	97	16.1	25	28.4
Hawaii	11	9.4	9	8.3	2	23.8
Idaho	8	6.4	6	5.2	2	22.2
Illinois	83	5.7	60	4.5	23	19.2
Indiana	54	7.4	39	5.9	15	21.7
Iowa	39	8.8	28	6.8	11	35.5
Kansas	25	7.0	19	5.8	6	24.0
Kentucky	69	13.5	52	11.7	17	25.4
Louisiana	75	15.0	59	13.5	16	25.0
Maine	21	12.0	15	9.4	6	37.5
Maryland	47	9.3	36	7.8	11	26.8
Massachusetts	75	9.2	55	7.3	20	32.3
Michigan	85	7.2	55	5.2	30	25.2

TABLE 29.—MEDICARE ENROLLMENT: NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE (SMI) UNDER BUY-IN AGREEMENTS, BY TYPE OF BENEFICIARY AND BY YEAR OR 1989 AREA OF RESIDENCE—Continued

Year or area of residence [1]	All persons		Aged		Disabled	
	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled
Minnesota	34	6.0	23	4.4	11	28.9
Mississippi	85	24.3	69	22.9	16	32.7
Missouri	49	6.6	35	5.1	14	20.6
Montana	10	8.9	7	6.9	3	30.0
Nebraska	10	4.4	6	2.8	4	28.6
Nevada	8	6.4	6	5.3	2	18.2
New Hampshire	3	2.4	2	1.6	1	13.3
New Jersey	90	8.6	69	7.2	21	26.3
New Mexico	21	12.6	17	11.4	4	22.8
New York	242	10.2	179	8.2	63	30.7
North Carolina	100	11.9	80	10.7	20	21.3
North Dakota	4	3.9	3	3.0	1	18.6
Ohio	103	7.0	78	5.9	25	18.0
Oklahoma	49	11.4	40	10.2	9	25.7
Oregon	25	6.2	18	4.9	7	22.2
Pennsylvania	114	6.1	78	4.5	36	25.0
Rhode Island	10	6.6	7	5.1	3	24.7
South Carolina	69	16.6	54	14.9	15	27.8
South Dakota	6	5.2	4	3.9	2	24.1
Tennessee	103	15.7	80	13.7	23	29.9
Texas	236	13.7	195	12.3	41	28.9
Utah	9	6.1	6	4.4	3	27.3
Vermont	6	8.3	4	6.1	2	32.9
Virginia	69	10.2	53	8.7	16	23.2
Washington	50	8.7	35	6.6	15	31.9
West Virginia	25	8.3	18	7.0	7	16.3
Wisconsin	49	7.1	30	4.8	19	32.8
Wyoming [2]	0	0.0	0	0.0	0	0.0
Puerto Rico [2]	1	15.2	1	16.7	0	6.3
Guam and Virgin Islands [3]						

[1] State of residence is not necessarily State that bought coverage.

[2] No State buy-in agreement.

[3] Data for these areas combined to prevent disclosure of confidential information.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, "HCFA Statistics" and unpublished data.

TABLE 30.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS, BY TYPE OF COVERAGE AND TYPE OF SERVICE, AND BY YEAR OR TYPE OF ENROLLEE

Type of coverage and type of service	Amount and distribution of payments for all enrollees, calendar year—									
	1975		1980		1981		1982		1983	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total payments (millions)	15,588	100.0	35,686	100.0	43,442	100.0	51,086	100.0	57,443	100.0
Hospital insurance	11,315	72.6	25,051	70.2	30,329	69.8	35,631	69.7	39,337	68.5
Inpatient	10,877	69.8	24,082	67.5	29,071	66.9	33,902	66.4	37,206	64.8
Skilled nursing facility	278	1.8	401	1.1	438	1.0	478	.9	517	.9
Home health agency	160	1.0	568	1.6	820	1.9	1,251	2.4	1,614	2.8
Supplementary medical insurance	4,273	27.4	10,635	29.8	13,113	30.2	15,455	30.3	18,106	31.5
Physicians'	3,415	21.9	8,188	22.9	10,085	23.2	11,893	23.3	14,063	24.5
Outpatient hospital	652	4.2	1,935	5.4	2,447	5.6	3,031	5.9	3,387	5.9
Home health agency	87	.6	195	.5	153	.4	17	0	22	0
Group practice plan	80	.5	203	.6	274	.6	335	.7	410	.7
Independent laboratory	39	.3	114	.3	154	.4	179	.4	224	.4

TABLE 30.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS, BY TYPE OF COVERAGE AND TYPE OF SERVICE, AND BY YEAR OR TYPE OF ENROLLEE—Continued

Type of coverage and type of service	Amount and distribution of payments for all enrollees, calendar year—											
	1984		1985		1986		1987		1988		1989	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total payments (millions)	62,870	100.0	70,391	100.0	75,844	100.0	80,162	100.0	86,318	100.0	98,097	100.0
Hospital insurance	43,209	68.7	47,444	67.4	49,605	65.4	49,342	61.6	52,349	60.6	59,803	61.0
Inpatient	40,731	64.8	44,698	63.5	46,746	61.6	46,446	57.9	49,265	57.1	54,277	55.3
Skilled nursing facility	543	.9	578	.8	587	.8	631	.8	666	.8	2,783	2.8
Home health agency	1,929	3.1	2,148	3.1	2,230	2.9	2,195	2.7	2,320	2.7	2,608	2.7
Hospice	6	0	20	0	42	.1	70	.1	98	.1	135	0.1
Supplementary medical insurance	19,661	31.3	22,947	32.6	26,239	34.6	30,820	38.4	33,969	39.4	38,294	39.0
Physicians'	15,434	24.5	17,311	24.6	19,212	25.3	22,619	28.2	24,355	28.2	27,075	27.6
Outpatient hospital	3,450	5.5	4,304	6.1	5,144	6.8	5,903	7.4	6,545	7.6	7,675	7.8
Home health agency	32	.1	54	.1	45	.1	52	.1	52	.1	60	0.1
Group practice plan	464	.7	720	1.0	1,113	1.5	1,361	1.7	2,019	2.3	2,308	2.4
Independent laboratory	281	.4	558	.8	725	1.0	885	1.1	998	1.2	1,176	1.2

Source: Health Care Financing Administration, Bureau of Data Management and Strategy and Office of the Actuary, unpublished data.

TABLE 31.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS, BY TYPE OF COVERAGE AND TYPE OF SERVICE, AND BY TYPE OF ENROLLEE, 1989

	1989 payments by type of enrollee, calendar year—					
	All enrollees		Aged		Disabled	
	Amount (in millions)	Percentage distribution	Amount in millions	Percentage distribution	Amount (in millions)	Percentage distribution
Total payments (millions)	98,097	100.0	87,572	100.0	10,525	100.0
Hospital insurance	59,803	61.0	53,495	61.1	6,308	59.9
Inpatient	54,277	55.3	48,264	55.1	6,013	57.1
Skilled nursing facility	2,783	2.8	2,681	3.1	102	1.0
Home health agency	2,608	2.7	2,422	2.8	186	1.8
Hospice	135	.1	128	.1	7	.1
Supplementary medical insurance	38,294	39.0	34,077	38.9	4,217	40.1
Physicians'	27,075	27.6	24,629	28.1	2,446	23.2
Outpatient hospital	7,675	7.8	6,216	7.1	1,459	13.9
Home health agency	60	.1	60	.1	0	.0
Group practice plan	2,308	2.4	2,100	2.4	208	2.0
Independent laboratory	1,176	1.2	1,072	1.2	104	1.0

Source: Health Care Financing Administration. Bureau of Data Management and Strategy and Office of the Actuary, unpublished data.

TABLE 32.—PERSONS SERVED AND REIMBURSEMENTS FOR AGED MEDICARE ENROLLEES, BY TYPE OF COVERAGE AND BY YEAR OR 1988 DEMOGRAPHIC CHARACTERISTICS

Year, period, or 1988 characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Year:									
1968	397.8	$670	$267	204.0	$934	$191	394.8	$204	$81
1975	527.9	1,055	557	220.9	1,855	410	536.0	296	159
1980	637.7	1,791	1,142	240.0	3,379	811	652.3	545	356
1981	655.0	2,024	1,326	243.4	3,877	944	669.5	613	410
1982	641.4	2,439	1,565	250.7	4,462	1,119	653.8	733	479
1983	660.2	2,611	1,724	250.9	4,804	1,205	672.2	825	555
1984	685.7	NA	NA	239.6	NA	NA	698.9	NA	NA
1985	722.1	2,762	1,995	218.8	6,167	1,350	739.1	933	690
1986	731.7	2,870	2,100	213.0	6,528	1,390	750.8	1,012	760
1987	754.1	3,025	2,281	209.8	6,903	1,448	775.9	1,148	891
1988	767.8	3,178	2,440	207.5	7,515	1,559	792.5	1,192	945
Annual percentage change in period:									
1968 to 1975	4.1	6.7	11.1	1.1	10.3	11.5	4.5	5.5	10.2
1975 to 1981	3.7	11.5	15.6	1.6	13.1	14.9	3.8	12.9	17.2
1981 to 1988	2.3	6.7	9.1	−2.3	9.9	7.4	2.4	10.0	12.7
Age:									
65 and 66 years	705.7	$2,292	$1,618	134.4	$7,300	$981	763.1	$932	$711
67 and 68 years	674.6	2,658	1,793	143.7	7,597	1,091	704.6	1,074	757
69 and 70 years	726.7	2,823	2,051	162.0	7,747	1,255	744.3	1,132	843
71 and 72 years	753.0	3,040	2,289	180.4	7,858	1,418	766.4	1,197	918

73 and 74 years	777.0	3,224	2,505	199.6	7,851	1,567	789.5	1,254	990
75 to 79 years	803.6	3,464	2,784	229.9	7,715	1,774	815.8	1,317	1,075
80 to 84 years	841.4	3,665	3,083	279.0	7,308	2,039	854.7	1,317	1,125
85 years and over	857.4	3,940	3,378	335.1	7,040	2,359	899.0	1,211	1,089
Sex:									
Male	724.2	3,632	2,630	215.6	7,949	1,714	753.8	1,306	985
Female	797.0	2,902	2,313	202.0	7,202	1,455	817.9	1,123	919
Race:									
White	774.5	3,139	2,431	208.1	7,403	1,541	797.1	1,182	942
All other	708.4	3,626	2,569	204.1	8,678	1,771	746.4	1,304	973
Census region:									
Northeast	800.1	3,394	2,716	206.5	8,575	1,771	822.4	1,226	1,008
North Central	778.5	3,036	2,364	212.6	7,253	1,542	793.0	1,081	857
South	787.3	3,065	2,413	225.2	6,785	1,528	803.9	1,175	945
West	726.9	3,383	2,459	180.6	8,407	1,518	741.9	1,360	1,009

NA—Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, "Annual Medicare Program Statistics."

TABLE 33.—PERSONS SERVED AND REIMBURSEMENTS FOR DISABLED MEDICARE ENROLLEES, BY TYPE OF COVERAGE AND BY YEAR OR 1988 DEMOGRAPHIC CHARACTERISTICS

Year, period or 1988 characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Year:									
1968	NA	NA	NA	NA	NA	NA	NA	NA	NA
1975	449.5	$1,548	$696	219.2	$2,077	$455	471.4	$565	$266
1980	594.1	2,544	1,511	245.7	3,798	933	633.8	994	630
1981	615.2	2,881	1,772	251.4	4,400	1,106	655.9	1,104	724
1982	608.9	3,431	2,089	256.9	5,110	1,313	650.5	1,303	848
1983	628.8	3,658	2,300	257.7	5,550	1,430	670.1	1,412	946
1984	639.5	NA	NA	242.6	NA	NA	683.5	NA	NA
1985	668.8	3,855	2,578	227.9	7,224	1,646	715.5	1,414	1,012
1986	681.0	4,032	2,746	226.3	7,623	1,725	729.0	1,519	1,107
1987	695.6	3,994	2,778	219.4	7,610	1,670	747.8	1,611	1,205
1988	703.7	4,115	2,896	209.3	8,373	1,753	760.0	1,644	1,249
Annual percentage change in period:									
1968 to 1975	NA	NA	NA	NA	NA	NA	NA	NA	NA
1975 to 1981	5.4	10.9	16.9	2.3	13.3	16.0	5.7	11.8	18.1
1981 to 1988	1.9	5.2	7.3	−2.6	9.6	6.8	2.1	5.6	8.1

Age:									
Under 35 years	650.7	$4,197	$2,731	187.0	$8,865	$1,658	697.0	$1,670	$1,164
35 to 44 years	644.4	3,878	2,499	177.0	8,211	1,454	703.9	1,643	1,156
45 to 54 years	684.0	4,083	2,793	201.0	8,162	1,641	743.7	1,705	1,268
55 to 59 years	714.0	4,233	3,023	221.3	8,349	1,848	775.1	1,665	1,290
60 to 64 years	782.4	4,161	3,256	242.6	8,393	2,037	835.6	1,577	1,318
Sex:									
Male	652.5	4,067	2,654	196.2	8,397	1,648	709.2	1,563	1,109
Female	791.8	4,183	3,312	231.9	8,338	1,934	845.6	1,757	1,486
Race:									
White	704.3	3,830	2,698	205.0	8,063	1,653	763.1	1,501	1,146
All other	699.4	5,156	3,606	225.9	9,372	2,117	747.1	2,159	1,613
Census region:									
Northeast	740.3	4,379	3,242	204.7	9,577	1,961	799.3	1,749	1,398
North Central	714.5	3,913	2,796	211.7	8,293	1,756	765.2	1,473	1,127
South	709.5	3,976	2,821	229.8	7,498	1,723	745.6	1,566	1,168
West	713.7	4,591	3,277	193.6	9,718	1,881	757.6	1,975	1,497

NA—Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, "Annual Medicare Program Statistics."

TABLE 34.—USE OF INPATIENT HOSPITAL SERVICES BY MEDICARE ENROLLEES, BY TYPE OF ENROLLEE AND TYPE OF HOSPITAL: CALENDAR YEAR 1989 [1]

Type of enrollee and type of hospital	Bills [2]		Covered days of care			Reimbursements in dollars		
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per bill	Per 1,000 enrollees	Amount in millions	Per bill	Per 1,000 enrollees
All enrollees:								
All hospitals	10,639	322	90,751	8.5	2,747	[3] 53,563	5,035	1,621
Short-stay	10,227	310	85,243	8.3	2,580	[3] 51,994	5,084	1,574
Long-stay	412	12	5,508	13.4	167	1,569	3,805	47
Psychiatric	254	8	3,116	12.2	94	651	2,557	20
All other	158	5	2,393	15.2	72	918	5,814	28
Aged:								
All hospitals	9,329	312	79,321	8.5	2,656	[3] 47,382	5,079	1,586
Short-stay	9,092	304	75,987	8.4	2,544	[3] 46,316	5,094	1,551
Long-stay	237	8	3,335	14.1	112	1,066	4,495	36
Psychiatric	100	3	1,264	12.7	42	281	2,812	9
All other	137	5	2,070	15.1	69	786	5,717	26
Disabled:								
All hospitals	1,310	413	11,430	8.7	3,605	[3] 6,180	4,719	1,949
Short-stay	1,134	358	9,256	8.2	310	[3] 5,678	5,005	1,791
Long-stay	175	55	2,174	12.4	686	503	2,870	158
Psychiatric	155	49	1,852	12.0	584	370	2,393	117
All other	21	6	322	15.7	102	133	6,464	42

---

[1] Preliminary data. Detail may not add due to rounding.

[2] Discharges not available by type of hospital.

[3] Adjusted for estimated PPS passthrough amounts.

Note: Only services rendered by inpatient hospitals are included.

Source: Health Care Financing Administration, Bureau of Management and Strategy, unpublished data.

TABLE 35.—USE OF SHORT-STAY HOSPITAL SERVICES BY AGED MEDICARE ENROLLEES, BY CALENDAR YEAR OR 1988 DEMOGRAPHIC CHARACTERISTICS

Calendar year, period, or 1988 characteristic	Aged hospital insurance enrollees (in thousands) [1]	Discharges		Total days of care			Total charges			
		Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per discharge	Per 1,000 enrollees	Amount (in millions)	Per discharge	Per covered day of care	Per enrollee
Year:										
1969	20,014	6,855	342	78,346	11.4	3,915	$5,261	$768	$67	$263
1975	22,472	7,285	324	81,592	11.2	3,631	11,853	1,627	145	527
1980	25,104	9,051	361	96,772	10.7	3,855	28,114	3,106	291	1,120
1981	25,591	9,400	367	98,223	10.3	3,838	33,564	3,571	342	1,312
1982	26,115	9,817	376	100,431	10.0	3,846	40,875	4,164	407	1,565
1983	26,670	10,152	381	99,740	9.9	3,740	47,851	4,713	480	1,794
1984	27,112	9,705	358	86,062	8.9	3,174	46,964	4,839	546	1,732
1985	27,683	8,918	322	76,926	8.6	2,779	47,371	5,312	616	1,711
1986	28,257	8,917	316	77,240	8.7	2,733	52,623	5,901	681	1,862
1987	28,882	9,000	312	79,804	10.2	2,769	60,900	6,767	763	2,113
1988 [2]	29,312	9,146	312	80,938	10.2	2,761	69,920	7,645	864	2,385
Annual percentage change in period:										
1975 to 1981	2.2	4.3	2.1	3.1	−1.4	.9	18.9	14.0	15.3	16.4
1981 to 1988	1.7	−.6	−2.3	−2.9	−.1	−4.6	8.9	9.6	12.2	7.0
Age:										
65 to 69 years	9,311	NA	NA	NA	NA	NA	NA	NA	NA	NA
70 to 74 years	7,605	NA	NA	NA	NA	NA	NA	NA	NA	NA
75 to 79 years	5,650	NA	NA	NA	NA	NA	NA	NA	NA	NA
80 to 84 years	3,659	NA	NA	NA	NA	NA	NA	NA	NA	NA
85 years or over	3,086	NA	NA	NA	NA	NA	NA	NA	NA	NA

TABLE 35.—USE OF SHORT-STAY HOSPITAL SERVICES BY AGED MEDICARE ENROLLEES, BY CALENDAR YEAR OR 1988 DEMOGRAPHIC CHARACTERISTICS—Continued

Calendar year, period, or 1988 characteristic	Aged hospital insurance enrollees (in thousands) [1]	Discharges		Total days of care			Total charges			
		Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per discharge	Per 1,000 enrollees	Amount (in millions)	Per discharge	Per covered day of care	Per enrollee
Sex:										
Male	11,811	NA	NA	NA	NA	NA	NA	NA	NA	NA
Female	17,500	NA	NA	NA	NA	NA	NA	NA	NA	NA
Race: [3]										
White	25,728	NA	NA	NA	NA	NA	NA	NA	NA	NA
All other	2,688	NA	NA	NA	NA	NA	NA	NA	NA	NA
Census region:										
Northeast	6,553	NA	NA	NA	NA	NA	NA	NA	NA	NA
North central	7,370	NA	NA	NA	NA	NA	NA	NA	NA	NA
South	9,630	NA	NA	NA	NA	NA	NA	NA	NA	NA
West	5,164	NA	NA	NA	NA	NA	NA	NA	NA	NA

[1] As of July 1.

[2] Preliminary. Final data are estimated to be about 3 percent higher than the amounts shown for 1988.

[3] Excludes unknown race.

NA—Not available.

Note: Only services rendered by short-stay hospitals are included.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data.

TABLE 36.—USE OF SKILLED NURSING FACILITY SERVICES AND PERCENTAGE CHANGE, BY TYPE OF MEDICARE ENROLLEE, AND CALENDAR YEAR OR PERIOD, OR 1988 DEMOGRAPHIC CHARACTERISTIC

Type of enrollee and year, period, or 1988 characteristic	Number of SNF facilities [1]	HI enrollees (in thousands) [2]	Persons served		Covered days of care			Reimbursements			
			Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per person served	Per enrollee	Amounts (in millions)	Per person served	Per enrollee	Per day
				Aged							
Year:											
1969 [3]	4,786	20,014	394	19.7	17,520	45	.9	$311	$790	$16	$18
1975	3,932	22,472	260	11.5	8,585	33	.4	233	896	10	27
1980	5,155	25,104	248	9.9	8,410	34	.3	331	1,336	13	39
1981	5,295	25,591	243	9.5	8,373	34	.3	361	1,486	14	43
1982	5,510	26,115	244	9.3	8,549	35	.3	388	1,591	15	45
1983	5,760	26,670	257	9.6	9,007	35	.3	413	1,612	16	46
1984	6,183	27,112	290	10.7	9,309	32	.3	458	1,581	17	49
1985	6,725	27,683	304	11.0	8,615	28	.3	464	1,525	17	54
1986	7,065	28,257	294	10.4	7,867	27	.3	474	1,613	17	60
1987	7,148	28,822	283	9.8	7,139	25	.2	524	1,853	18	73
1988	7,683	29,312	371	12.7	10,681	29	.4	811	2,184	28	76
Annual percentage change in period:											
1969 to 1975	−3.2	1.9	−6.7	−8.5	−11.2	−4.8	−12.9	−4.7	2.1	−6.6	7.3
1975 to 1981	5.1	2.2	−1.1	−3.2	−.4	0.7	−2.5	7.6	8.8	5.3	8.1
1981 to 1988	4.4	1.7	2.2	.5	−2.3	−4.3	−3.9	5.5	3.2	3.7	7.9
Age:											
65 to 69 years		9,311	30	3.3	NA	NA	NA	69	2,285	7	NA
70 to 74 years		7,605	51	6.8	NA	NA	NA	118	2,303	16	NA
75 to 79 years		5,650	75	13.3	NA	NA	NA	167	2,213	30	NA
80 to 84 years		3,659	87	23.9	NA	NA	NA	191	2,181	52	NA
85 years or over		3,086	127	41.0	NA	NA	NA	265	2,096	86	NA

TABLE 36.—USE OF SKILLED NURSING FACILITY SERVICES AND PERCENTAGE CHANGE, BY TYPE OF MEDICARE ENROLLEE, AND CALENDAR YEAR OR PERIOD, OR 1988 DEMOGRAPHIC CHARACTERISTIC—Continued

Type of enrollee and year, period, or 1988 characteristic	Number of SNF facilities [1]	HI enrollees (in thousands) [2]	Persons served		Covered days of care			Reimbursements			
			Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per person served	Per enrollee	Amounts (in millions)	Per person served	Per enrollee	Per day
Sex:											
Male		11,811	119	10.1	NA	NA	NA	256	2,142	22	NA
Female		17,500	252	14.4	NA	NA	NA	555	2,204	32	NA
Race: [4]											
White		25,728	338	13.1	NA	NA	NA	726	2,151	28	NA
All other		2,688	25	9.1	NA	NA	NA	62	2,544	23	NA
Census region:											
Northwest	1,727	6,553	65	10.0	2,543	39	0.4	148	2,273	23	58
North Central	2,175	7,370	122	16.5	3,329	27	0.5	251	2,066	34	76
South	1,887	9,630	93	9.7	2,610	28	0.3	187	2,006	19	72
West	1,712	5,164	90	17.4	2,140	24	0.4	222	2,472	43	104
DISABLED											
Year:											
1974 [4]	3,892	1,928	8	4.1	277	35	.1	$7	$936	$4	$27
1975	3,932	2,168	8	3.9	289	34	.1	9	1,049	4	30
1980	5,155	2,963	9	2.9	319	38	.1	13	1,571	5	42
1981	5,295	2,999	8	2.8	310	37	.1	14	1,693	5	45
1982	5,510	2,954	8	2.6	296	38	.1	14	1,762	5	46
1983	5,760	2,918	8	2.7	305	38	.1	15	1,856	5	48
1984	6,183	2,884	9	3.1	314	35	.1	15	1,675	5	47
1985	6,725	2,907	10	3.5	305	30	.1	17	1,681	6	57
1986	7,065	2,959	10	3.5	292	29	.1	19	1,872	6	65

1987	7,148	3,031	10	3.3	272	27	.1	21	2,154	7	79
1988	7,683	3,101	13	4.2	401	31	.1	33	2,529	11	81
Annual percentage change in period:											
1974 to 1975	1.0	12.5	5.7	−6.0	4.4	−1.3	−7.2	18.5	12.1	5.3	13.5
1975 to 1981	5.1	5.6	−.2	−5.5	1.2	1.4	4.2	8.1	8.3	2.4	6.8
1981 to 1988	4.4	.2	32.6	2.5	−1.8	−4.4	−2.0	6.2	3.5	6.1	8.2
Age:											
Under 35 years		471	1	1.7	NA	NA	NA	2	2,806	5	NA
35 to 44 years		572	1	2.4	NA	NA	NA	4	2,912	7	NA
45 to 54 years		670	2	3.6	NA	NA	NA	6	2,441	9	NA
55 to 64 years		1,388	8	6.0	NA	NA	NA	20	2,465	15	NA
Sex:											
Male		1,962	7	3.5	NA	NA	NA	17	2,509	9	NA
Female		1,140	6	5.3	NA	NA	NA	15	2,552	13	NA
Race: [5]											
White		2,419	10	4.2	NA	NA	NA	26	2,496	11	NA
All other		624	2	3.6	NA	NA	NA	6	2,683	10	NA
Census region: [6]											
Northeast	1,689	618	2	2.9	75	42	0.1	4	2,502	7	59
North Central	2,025	738	4	5.7	132	31	0.2	11	2,481	14	79
South	1,772	1,136	4	3.1	105	29	0.1	8	2,218	7	75
West	1,656	501	3	6.5	84	26	0.2	10	2,965	19	115

---

[1] Number serving either aged or disabled Medicare enrollees, as of January 1989.

[2] As of July 1.

[3] Earliest year for SNF utilization data.

[4] First full year of disability coverage under Medicare.

[5] Excludes unknown race.

[6] Regions exclude residence unknown and territories.

NA—Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data.

TABLE 37.—VISITS, CHARGES, AND REIMBURSEMENTS FOR HOME HEALTH AGENCY SERVICES AND PERCENTAGE CHANGES BY CALENDAR YEAR OR PERIOD, OR DEMOGRAPHIC CHARACTERISTICS

Calendar year, period, or 1989 characteristic [2]	Visits		Charges [1]			Reimbursements					
						Amount (in millions)					
	Number in millions	Per 1,000 enrollees	Total amount (in millions)	Amount (in millions) for visits	Amount per visit	HI	SMI	Total	Average annual percentage change in total	Total per visit	Total per enrollee
Year:											
1969	9	424	$88	NA	NA	$52	$26	$78	....	$9	$4
1975	11	431	226	211	20	152	63	215	18.4	20	9
1980	23	792	775	739	33	490	176	666	25.4	30	23
1981	26	902	991	945	36	760	100	860	29.1	33	30
1982	31	1,061	1,313	1,248	40	1,105	16	1,121	30.4	36	38
1983	38	1,253	1,689	1,627	43	1,405	22	1,427	27.3	38	48
1984	41	1,358	2,026	1,912	46	1,677	27	1,704	19.4	41	56
1985	40	1,303	2,152	1,979	49	1,766	31	1,797	5.4	44	58
1986	39	1,229	2,214	2,125	54	1,781	36	1,817	1.1	47	57
1987	37	1,138	2,236	2,127	58	1,774	39	1,813	−0.2	49	56
1988	38	1,156	2,472	2,358	62	1,916	43	1,960	8.1	51	59
1989	47	1,404	3,233	3,016	66	2,368	57	2,426	23.8	51	72
Annual percentage change in period:											
1969 to 1975	4.0	.3	17.1	NA	NA	19.7	15.8	18.4	....	13.9	14.2
1975 to 1981	16.0	13.1	27.9	28.4	10.3	30.8	8.0	26.0	....	8.6	22.9
1981 to 1989	4.8	3.1	12.1	12.1	7.0	12.3	−9.8	10.8	....	5.8	9.1
Type of enrollee:											
Aged	44	1,468	3,002	2,890	66	2,199	57	2,257	....	51	76
Disabled	3	1,057	231	216	66	169	0	169	....	51	54

Sex:											
Male	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Female	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Race: [2]											
White	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
All other	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

---

[1] Excludes durable medical equipment and supplies, except for drugs and biologicals, furnished by home health agencies.
[2] Data for 1989 as of November 1990.

NA—Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data.

TABLE 38.—SELECTED UTILIZATION AND REIMBURSEMENT DATA FOR END-STAGE RENAL DISEASE, AND KIDNEY TRANSPLANT PROGRAMS, FOR SELECTED CALENDAR YEARS

Program and key program variables	1975	1983	1984	1985	1986	1987	1988
End-stage renal disease program: [1]							
Beneficiaries:							
Number	12,702	28,847	29,698	30,876	38,970	47,222	53,247
Percentage change [2]		10.8	3.0	4.0	26.2	21.2	12.8
Expenditures:							
Total (in millions)	$199	$727	$633	$635	$779	$1,031	1,231
Percentage change [2]		17.6	−12.9	0.3	22.7	32.3	19.4
Expenditure per beneficiary:							
Amount (in dollars) [3]	15,668	26,107	21,315	20,566	19,900	21,833	23,119
Percentage change [2]		6.6	−18.4	−3.5	−3.2	9.7	5.9
New beneficiaries during year:							
Number	6,763	6,738	7,532	9,372	14,696	15,570	17,416
Percentage change [2]		0.0	11.8	24.4	56.8	5.9	11.9

Kidney transplant program: [4]							
Total transplants:							
Number of patients	[5] 3,730	5,616	6,029	7,073	8,258	8,298	8,085
Percentage change [2]		5.2	7.4	17.3	16.8	0.5	−2.6
Kidney transplanted from living donors: [6]							
Number	NA	1,784	1,704	1,876	1,887	1,907	1,760
Percentage of total transplants		31.91	27.03	26.52	22.85	22.98	23.0
Number of beneficiaries losing entitlement because of 3-year limitation	NA	NA	NA	NA	NA	NA	NA

---

[1] Persons entitled solely because of end-stage renal disease.
[2] For intervals of more than 1 year, rate shown is average annual rate of change.
[3] Not adjusted for PPS pass-throughs.
[4] Transplants in Medicare-certified United States hospitals.
[5] Transplant count for 1975 includes non-Medicare patients.
[6] Includes transplants to non-Medicare patients.

NA—Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data.

TABLE 39.—MEDICARE UTILIZATION AND REIMBURSEMENT: NUMBER OF AGED PERSONS SERVED UNDER HOSPITAL INSURANCE AND/OR SUPPLEMENTARY MEDICAL INSURANCE PER 1,000 ENROLLED, AMOUNT REIMBURSED PER PERSON SERVED, AND PERCENTAGE CHANGE, BY CENSUS DIVISION AND STATE, FOR SELECTED CALENDAR YEARS

	Persons served per 1,000 enrolled									Reimbursement per person served								
						Annual percent change									Annual percent change			
	1967	1985	1986	1987	1988	1967–87	1985–86	1986–87	1987–88	1967	1985	1986	1987	1988	1967–87	1985–86	1986–87	1987–88
Total, all areas [1]	366.5	772.1	731.7	754.1	767.8	3.7	1.3	3.1	1.8	$592	$2,762	$2,870	$3,025	$3,177	8.5	3.9	5.4	5.0
United States [2]	370.9	731.2	741.2	762.9	776.6	3.7	1.4	2.9	1.8	593	2,772	2,881	3,036	3,189	8.5	3.9	5.4	5.0
New England	380.4	767.4	772.4	779.6	788.6	3.7	.7	.9	1.2	680	2,708	2,775	2,890	3,046	7.5	2.5	4.1	5.4
Maine	330.1	756.1	790.9	832.3	848.2	4.7	4.6	5.2	1.9	586	2,369	2,209	2,300	2,605	7.1	−6.8	4.1	13.3
New Hampshire	391.6	739.7	753.2	766.1	779.8	3.4	1.8	1.7	1.8	467	2,374	2,396	2,553	2,452	8.9	.9	6.6	−3.9
Vermont	411.7	742.8	774.1	800.0	815.9	3.4	4.2	3.3	2.0	515	1,990	2,212	2,158	2,410	7.4	11.2	−2.4	11.7
Massachusetts	394.2	766.5	762.2	761.5	774.9	3.3	−.6	−.1	1.8	708	2,971	3,085	3,239	3,377	7.9	3.8	5.0	4.3
Rhode Island	375.4	829.6	824.2	809.2	754.9	3.9	−.7	−1.8	−6.7	625	2,619	2,675	2,632	2,548	7.5	2.1	−1.6	−3.2
Connecticut	390.9	764.1	772.4	783.9	800.8	3.5	1.1	1.5	2.2	711	2,570	2,651	2,796	3,055	7.1	3.2	5.5	9.3
Middle Atlantic	388.1	768.2	776.4	797.0	804.0	3.7	1.1	2.7	.9	578	2,771	2,986	3,265	3,511	9.0	7.8	9.3	7.5
New York	406.9	765.7	774.6	800.9	797.0	3.4	1.2	3.4	−.5	610	2,533	2,795	3,291	3,581	8.8	10.3	17.7	8.8
New Jersey	399.0	759.8	762.0	775.8	788.4	3.4	.3	1.8	1.6	526	2,650	2,906	3,109	3,363	9.3	9.7	7.0	8.2
Pennsylvania	365.0	776.4	787.0	803.8	821.8	4.0	1.4	2.1	2.2	533	3,147	3,277	3,315	3,502	9.6	4.1	1.2	5.6
East North Central	350.2	725.9	745.1	771.5	793.7	4.0	2.6	3.5	2.9	614	2,906	3,013	3,109	3,191	8.4	3.7	3.2	2.6
Ohio	353.6	718.4	753.5	790.1	808.2	4.1	4.9	4.9	2.3	585	2,792	2,995	3,152	3,205	8.8	7.3	5.2	1.7
Indiana	343.7	672.2	707.4	736.6	763.5	3.9	5.2	4.1	3.7	545	2,510	2,699	2,769	2,864	8.5	7.5	2.6	3.4
Illinois	339.2	693.4	701.4	727.4	748.1	3.9	1.2	3.7	2.8	703	3,313	3,402	3,418	3,429	8.2	2.7	.5	.3
Michigan	379.5	804.3	811.4	816.1	847.6	3.9	.9	.6	3.9	532	2,991	3,017	3,196	3,373	9.4	.9	5.9	5.5
Wisconsin	354.7	736.9	751.2	790.5	803.3	4.1	1.9	5.2	1.6	639	2,527	2,559	2,583	2,684	7.2	1.3	.9	3.9
West North Central	363.2	693.4	695.2	724.1	746.0	3.5	.3	4.2	3.0	558	2,627	2,625	2,653	2,685	8.1	−.1	1.1	1.2
Minnesota	389.0	624.8	571.2	550.8	601.8	1.8	−8.6	−3.6	9.3	601	2,447	2,413	2,485	2,555	7.4	−1.4	3.0	2.8
Iowa	365.9	715.3	735.6	801.7	822.3	4.0	2.8	9.0	2.6	505	2,282	2,296	2,376	2,413	8.1	.6	3.5	1.6
Missouri	364.8	712.0	732.5	763.9	775.8	3.8	2.9	4.3	1.6	544	3,118	3,095	3,061	3,091	9.0	−.7	−1.1	1.0
North Dakota	441.2	730.7	766.7	798.6	823.3	3.0	4.9	4.2	3.1	492	2,466	2,586	2,786	2,692	9.1	4.9	7.7	−3.4
South Dakota	358.0	694.2	718.3	778.2	803.9	4.0	3.5	8.3	3.3	514	2,281	2,404	2,437	2,323	8.1	5.4	1.4	−4.7
Nebraska	352.5	634.2	663.9	736.4	746.1	3.8	4.7	10.9	1.3	540	2,449	2,243	2,248	2,363	7.4	−8.4	.2	5.1
Kansas	365.3	765.4	759.3	776.4	780.7	3.8	−.8	2.3	.6	540	2,553	2,633	2,646	2,680	8.3	3.1	.5	1.3

South Atlantic	350.5	740.4	748.6	774.0	793.3	4.0	1.1	3.4	2.5	554	2,531	2,674	2,863	3,073	8.6	5.6	7.1	7.3
Delaware	368.2	770.9	798.5	802.4	814.2	4.0	3.6	.5	1.5	552	2,612	2,841	2,805	2,975	8.5	8.8	-1.3	6.1
Maryland	349.4	757.6	769.5	792.9	814.0	4.2	1.6	3.0	2.7	564	2,975	3,116	3,364	3,768	9.3	4.7	8.0	12.0
District of Columbia	452.8	739.4	763.2	770.5	781.3	2.7	3.2	1.0	1.4	570	3,774	3,637	4,399	5,229	10.8	-3.6	21.0	18.9
Virginia	317.3	729.7	747.4	778.4	811.1	4.6	2.4	4.1	4.2	516	1,976	2,597	2,641	2,849	8.5	31.4	1.7	7.9
West Virginia	342.2	692.0	718.1	759.3	778.6	4.1	3.8	5.7	2.5	489	2,575	2,654	2,634	2,738	8.8	3.1	-.8	3.9
North Carolina	324.0	727.9	739.1	768.6	797.3	4.4	1.5	4.0	3.7	515	1,982	2,071	2,278	2,491	7.7	4.5	10.0	9.4
South Carolina	296.2	680.6	698.3	718.1	716.3	4.5	2.6	2.8	-.3	523	2,340	2,325	2,437	2,412	8.0	-.6	4.8	-1.0
Georgia	320.2	743.5	750.4	777.4	803.1	4.5	.9	3.6	3.3	474	2,479	2,627	2,799	2,999	9.3	6.0	6.5	7.1
Florida	420.9	759.1	757.5	780.1	794.0	3.1	-.2	3.0	1.8	588	2,773	2,838	3,086	3,289	8.6	2.3	8.7	6.6
East South Central	332.1	698.1	729.7	765.4	775.9	4.3	4.5	4.9	1.4	489	2,570	2,704	2,812	2,890	9.1	5.2	4.0	2.8
Kentucky	365.9	671.9	711.2	753.4	788.7	3.7	5.8	5.9	4.7	458	2,395	2,612	2,750	2,992	9.4	9.1	5.3	8.8
Tennessee	354.8	678.7	708.6	750.0	779.8	3.8	4.4	5.8	4.0	502	2,816	2,916	2,960	3,070	9.3	3.6	1.5	3.7
Alabama	322.7	743.8	774.7	797.7	748.4	4.6	4.2	3.0	-6.2	490	2,502	2,667	2,813	2,613	9.1	6.6	5.5	-7.1
Mississippi	283.2	699.9	724.9	760.5	793.8	5.1	3.6	4.9	4.4	471	2,480	2,504	2,620	2,823	9.0	1.0	4.6	7.7
West South Central	374.8	687.4	715.1	757.7	783.6	3.6	4.0	6.0	3.4	504	2,811	2,909	3,004	3,164	9.3	3.5	3.3	5.3
Arkansas	319.3	715.4	739.1	779.1	812.1	4.6	3.3	5.4	4.2	466	2,550	2,527	2,583	2,686	8.9	-.9	2.2	4.0
Louisiana	343.4	653.5	697.7	739.8	782.7	3.9	6.8	6.0	5.8	446	3,167	3,421	3,434	3,613	10.7	8.0	.4	5.2
Oklahoma	416.1	677.8	714.8	760.0	784.0	3.1	5.5	6.3	3.2	486	2,482	2,625	2,776	2,983	9.1	5.8	5.8	7.4
Texas	393.7	693.2	714.8	757.6	777.7	3.3	3.1	6.0	2.7	522	2,860	2,926	3,037	3,188	9.2	2.3	3.8	5.0
Mountain	417.1	716.6	716.3	728.3	744.0	2.8	0	1.7	2.2	560	2,637	2,724	2,796	2,955	8.4	3.3	2.6	5.7
Montana	416.5	679.7	698.6	727.9	755.7	2.8	2.8	4.2	3.8	505	2,348	2,495	2,655	2,777	8.7	6.3	6.4	4.6
Idaho	408.8	714.5	752.1	794.2	800.5	3.4	5.3	5.6	.8	467	2,384	2,230	2,329	2,471	8.4	-6.5	4.4	6.1
Wyoming	395.0	681.7	692.4	741.8	767.2	3.2	1.6	7.1	3.4	432	2,804	2,768	2,977	2,950	10.0	-1.3	5.7	.8
Colorado	475.4	704.0	718.6	704.6	700.7	2.0	2.1	-1.9	-.6	578	2,521	2,746	2,749	2,852	8.1	8.9	.1	3.7
New Mexico	377.6	689.8	678.2	682.9	723.8	3.0	-1.7	.7	6.0	513	2,462	2,584	2,638	2,738	8.5	5.0	2.1	3.8
Arizona	431.7	758.1	740.2	755.1	764.6	2.8	-2.4	2.0	1.3	612	2,896	2,943	3,007	3,197	8.3	1.6	2.2	6.3
Utah	346.0	713.1	726.7	748.9	779.5	3.9	1.9	3.1	4.1	580	2,225	2,325	2,427	2,635	7.4	4.5	4.4	8.6
Nevada	414.9	688.9	642.0	649.4	687.5	2.3	-6.8	1.2	5.9	532	3,243	3,354	3,488	3,752	9.9	3.4	4.0	7.6
Pacific	468.9	739.7	730.7	725.0	720.9	2.2	-1.2	-.8	-.6	630	6,153	3,163	3,373	3,540	8.8	-48.6	6.6	5.0
Washington	433.0	731.1	732.0	756.0	772.5	2.8	.1	3.3	2.2	507	2,522	2,475	2,618	2,815	8.6	-1.9	5.8	7.5
Oregon	392.6	716.2	703.1	700.5	696.3	2.9	-1.8	-.4	-.6	583	2,459	2,117	2,490	2,452	7.5	-13.9	17.6	-1.5
California	490.7	745.7	735.2	727.1	719.7	2.0	-1.4	-1.1	-1.0	653	3,379	3,447	3,649	3,843	9.0	2.0	5.9	5.3
Alaska	307.2	678.4	691.8	699.3	726.1	4.2	2.0	1.1	3.8	376	3,554	3,654	3,445	3,773	11.7	2.8	-5.7	9.5
Hawaii	407.4	709.3	703.1	602.8	581.4	2.0	-.9	-14.3	-3.6	572	2,334	2,255	2,674	2,759	8.0	-3.4	18.6	3.2

---

[1] Consists of United States, Puerto Rico, Virgin Islands, and other outlying areas.
[2] Consists of 50 States, District of Columbia, and residence unknown.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, "Annual Medicare Program Statistics," and unpublished data.

TABLE 40.—NUMBER OF PLANS AND PERSONS ENROLLED IN MEDICARE—CONTRACTING PREPAID HEALTH PLANS: PRE- AND POST-TEFRA

	Pre-TEFRA (March 1985)		Post-TEFRA (December 1990)	
	Plans	Enrollees	Plans	Enrollees
TEFRA risk				
Old risk	4	37,353	85	1,240,474
Cost basis	65	116,608	25	136,734
Demo	39	310,023	4	17,387
Total HMO	108	463,984	114	1,394,595
HCPP's and GPPP's	46	612,131	48	633,996
Total prepaid	154	1,076,115	162	2,028,591
Percent of total Medicare beneficiaries		3.6		6.0

TEFRA risk: Contracts with a Health Maintenance Organization (HMO) under authority of section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Old risk: Contracts under authority of section 1876, as it existed prior to TEFRA. HMO assumes full risk for costs of services to enrolled beneficiaries.

Cost basis: Contracts under authority of section 1876, but services rendered by HMO are reimbursed on a cost basis; HMO assumes no risk.

Demo: Projects operated on a demonstration basis. Current demonstration contracts are limited to Social Health Maintenance Organizations (SHMOs).

HCPPs, GPPPs: Health Care Payment Plans and Group PrePayment Plans contracts under authority of section 1833. HCPPs and GPPPs involve only Part B services, and are reimbursed at 80 percent of reasonable cost.

Source: Health Care Financing Administration.

RECENT LEGISLATIVE CHANGES

The major legislative changes enacted in the Omnibus Budget Reconciliation Acts of 1989 and 1990 and the Medicare Catastrophic Coverage Repeal Act of 1989 are described below in table 41.

Two additional Medicaid benefits under the act were not repealed and do not interact with Medicare provisions. First, States will be required to allow spouses of nursing home residents seeking Medicaid coverage to retain more income than previously, to protect against spousal impoverishment. Second, Medicaid benefits will be extended to all pregnant women and infants living in families with incomes below the poverty line.

TABLE 41.—COMPARISON OF CURRENT LAW MEDICARE BENEFIT STRUCTURE WITH THE CATASTROPHIC PROVISIONS

Provision	Current law	With catastrophic provisions
	Hospital insurance (part A) [1]	
Coverage	Hospital inpatient acute care. Short-term skilled nursing care. Intermittent home health care. Hospice care for terminally ill.	Same, with changes noted below.
Limits	Hospital stays limited to 90 days per spell of illness, plus up to 60 lifetime reserve days (with lifetime limit of 190 days for inpatient psychiatry).	No limit on covered inpatient days (except for psychiatric care where 190-day limit remains).
	SNF stays limited to 100 days per spell, covered only subsequent to hospital stay of at least 3 days.	SNF limit changed to 150 days a year, and no prior inpatient stay required for coverage.
	Lifetime limit of 210 days for hospice	No limit on hospice days.
	Consecutive days of home health care limited to 21.	Consecutive days of home health care limited to 38.
Deductibles	Inpatient deductible for first stay each spell.	Deductible for first stay each year.
	Blood deductible up to 3 units each spell	Blood deductible up to 3 units a year.
Coinsurance	Hospital coinsurance paid for days 61–90 (¼ deductible) and for reserve days (½ deductible).	No hospital coinsurance.
	SNF coinsurance paid for days 21–100 (⅛ deductible).	SNF coinsurance paid for days 1–8 each year.
	Hospice coinsurance of 5% of drug/respite charges.	(20% of daily cost).
	Supplementary medical insurance and catastrophic insurance (part B)	
Coverage	Physicians' services Hospital outpatient departments. Ambulatory surgicenters.	SMI program expanded to cover screening mammography and respite care.
	Laboratory services Intermittent home health care. Drugs for transplant patients (1 year only).	New Part B drug program introduced to cover prescription drugs and insulin.
Limits	Prevent services generally not covered Reimbursement limit of $1,100 a year for outpatient psychiatric services.	Respite care limited to 80 hours a year, and available only to those who exceed SMI copayment cap or drug deductible in the previous 12 months.
Deductible	Annual SMI deductible of $75	Same, plus separate drug deductible set to affect 16.8% of enrollees.
Coinsurance	Coinsurance of 20% of reasonable charges above deductible amount (50% for outpatient psychiatry).	Same, subject to SMI copayment cap.
Copayment cap	None	SMI copayment cap set to affect 7% of enrollees. No drug copayment cap.

---

[1] The act eliminated the spell of illness concept. A spell of illness began with a hospital admission and ended on the 61st day following discharge from the hospital or from a SNF entered subsequent to the hospital stay.

Source: Congressional Budget Office.

TABLE 42.—MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989

[By fiscal year, millions of dollars]

Provisions	1990	1991	1992	1993	1994	1990–94 total
I. Spending changes:						
Hospital	−814	−1,401	−1,522	−1,659	−1,803	−7,199
SNF [1]	−1,000	−2,800	−3,100	−3,200	−3,600	−13,700
Home health	−129	−183	−194	−208	−223	−937
Blood deductible	0	0	0	0	0	0
Hospice	−1	−1	−1	−1	−1	−5
Part B copay cap	−1,838	−3,197	−3,801	−4,326	−4,932	−18,094
Respite	−67	−161	−263	−418	−617	−1,526
Screening mammography	−75	−123	−138	−147	−156	−639
Home IV/immuno drugs	−76	−162	−185	−225	−274	−922
Other drugs	0	−1,464	−3,505	−4,029	−4,252	−13,250
Total Medicare spending	−4,000	−9,492	−12,709	−14,213	−15,858	−56,272
II. Income changes:						
Flat premium	1,459	2,732	3,586	4,147	4,619	16,543
Supplemental premium [2]	6,989	7,165	6,786	7,564	8,484	36,988
Total Medicare income	8,448	9,897	10,372	11,711	13,103	53,531
Net Medicare effect	4,448	405	−2,337	−2,502	−2,755	−2,741
III. Medicaid offset	242	618	832	922	1,029	3,642
IV. Net budget effect [3]	4,690	1,023	−1,505	−1,580	−1,726	901

[1] This estimate is based on transition rules as written (i.e. occupants of Medicare certified beds will be eligible for the transition rules).

[2] Revenue losses are shown with a positive sign to reflect their effect on the deficit.

[3] The net budget effect includes changes in revenues and direct spending outlays. Administrative costs are not included, effects on the Medicaid program are included.

Source: Congressional Budget Office, August baseline.

Financing

The financing provisions of the Medicare Catastrophic Coverage Act of 1988 prior to repeal are shown in table 43.

TABLE 43.—MEDICARE PREMIUMS PAYABLE PER ENROLLEE UNDER PUBLIC LAW 100–360 PRIOR TO REPEAL

[By calendar year]

	1989	1990	1991	1992	1993
Monthly flat premiums (per enrollee)	4.00	4.90	7.40	9.20	10.20
Supplemental premiums (annual surtax rates):					
Total percent (in law)	15.0	25.0	26.0	27.0	28.0
Maximum annual liability per enrollee	$800	$850	$900	$950	$1,050
Percent of enrollees paying maximum	5.6	9.3	9.8	10.3	10.3
Percent of enrollees paying	41.2	42.8	44.6	46.3	47.6
Percent of enrollees not paying	58.8	57.2	55.4	53.7	52.4

TABLE 44.—MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 DISTRIBUTION OF MEDICARE ENROLLEES BY LEVEL OF SUPPLEMENTAL PREMIUM

[Calendar Year 1990]

Supplemental premium per enrollee	Medicare enrollees (thousands)	Percent distribution
Not subject to premium	19,097	57.2
$100 to $199	4,908	15.0
$200 to $399	3,238	9.7
$400 to $599	1,970	5.9
$600 to $849	1,069	3.2
Maximum premium ($850)	3,105	9.3
Total	33,387	100.3

Source: Joint Committee on Taxation.

TABLE 45.—ESTIMATED BUDGET IMPACT OF MEDICARE RECONCILIATION PROVISIONS—(OBRA 1989)

[All estimates are from the February 1989 CBO baseline, outlays or revenues in millions of dollars, by fiscal year]

Provisions	1990	1991	1992	1993	1994	5-year total
PART 1—PART A						
Sequester order through December 31, 1989 (sec. 6001)	−280	0	0	0	0	−280
Reduction in payments for capital-related costs of inpatient hospital services for fiscal year 1990 (January 1, 1990 effective date) (sec. 6002)	−480	−100	0	0	0	−580
Prospective payment hospitals (sec. 6003):						
Changes in hospital update factors (Large urbans +.12; small urbans −.53; rurals +4.22; exempts—market basket)	100	180	190	210	230	910
Reduction in DRG weighting factors for fiscal year 1990 (−1.22%); future annual recalibration of DRG weights on budget-neutral basis	−460	−580	−640	−700	−760	−3,140
Increase of disproportionate share adjustment:						
Change in formula	80	235	260	285	310	1,170
Treatment of rural hospitals	15	50	55	60	65	245
Extension of regional referral center classification	0	25	30	15	0	70
Criteria and payment for sole community hospitals	10	75	120	140	150	495
Criteria and payment for Medicare dependent small rural hospitals	5	45	65	20	0	135
Essential access community hospital program:						
Grants to States and hospitals	25	25	25	0	0	75
Rural health care transition grants	10	25	25	0	0	60
Reimbursement of E.A.C. hospitals	0	10	20	25	25	80
Additional payment resulting from corrections of wage index	11	0	0	0	0	11
PPS-exempt hospitals (sec. 6004):						
Exempt cancer hospitals	15	1	1	1	1	19
Rebase cancer hospitals to 1987 costs	1	12	13	14	15	55
Payments for hospice care (sec. 6005)	15	25	30	35	40	145
Passthrough payment for hemophilia inpatients (sec. 6011)	4	32	13	0	0	49

Buy-in for continued benefits for disabled individuals (sec. 6012)	(1)	3	7	12	18	40
Extension of waiver for Finger Lakes Area Hospital Corporation (sec. 6022)	0	−(1)	−1	−1	−1	−3
Subtotal Part A:						
Outlays	−929	63	213	116	93	−444
Amounts subject to appropriations	(1)	(1)	(1)	(1)	(1)	(1)
PART 2—PART B						
Extension of reductions under sequester order (sec. 6101)	−355	0	0	0	0	−355
Physician payment reform (sec. 6102):						
Medicare volume performance standards	0	0	−90	−345	−615	−1,050
Direct submission of claims	24	170	185	205	225	809
Rural/Inner city access	0	20	30	35	40	125
Establishment of agency for health policy and research (sec. 6103):						
Direct spending	(1)	1	1	1	(1)	3
Subject to appropriations	19	58	116	152	167	512
Reduction in payments for certain procedures (sec. 6104) [2]	−125	−170	−190	−215	−240	−940
Reduction in payments for radiology services (sec. 6105)	−100	−150	−180	−200	−225	−855
Anesthesia services (sec. 6106)	−35	−45	−50	−55	−60	−245
Delay in update and reduction in percentage increase in MEI (sec. 6107):						
Delay update of all fees	−245	0	0	0	0	−245
Reduce update	−215	−345	−390	−440	−495	−1,885
Miscellaneous provisions relating to payment for physician services (sec. 6108):						
New physician customary charges	−25	−10	0	0	0	−35
Designated specialties	−45	−60	−70	−80	−90	−345
Waiver of liability (sec. 6109)	15	0	0	0	0	15
Reduction in capital payments for outpatient hospital services (sec. 6110)	−20	−3	0	0	0	−23
Clinical diagnostic lab tests (sec. 6111)	−85	−130	−155	−185	−215	−770
Durable medical equipment (sec. 6112)	−80	−125	−145	−160	−180	−690
Mental health services (sec. 6113):						
Direct payment for psychs, LCSWs	5	30	35	35	35	140
Eliminate $1,100 limit	5	35	50	60	75	225

TABLE 45.—ESTIMATED BUDGET IMPACT OF MEDICARE RECONCILIATION PROVISIONS—(OBRA 1989)—Continued

[All estimates are from the February 1989 CBO baseline, outlays or revenues in millions of dollars, by fiscal year]

Provisions	1990	1991	1992	1993	1994	5-year total
Interaction of above 2 items	1	8	10	11	13	43
Coverage of nurse practitioner services in nursing facilities (sec. 6114)	1	3	3	3	4	14
Coverage of screening pap smears (sec. 6115)	30	120	145	155	165	615
Coverage under, and payment for, outpatient rural primary care hospital services under part B (sec. 6116)	0	1	3	5	5	14
Payment limits for physical and occupational therapy (sec. 6133)	(1)	(1)	1	1	1	3
Narrowing range for DME (sec. 6140)	0	(1)	20	20	20	60
Subtotal Part B:						
Outlays	−1,249	−650	−787	−1,149	−1,537	−5,372
Amount subject to appropriation	19	58	116	152	167	512
PART 3—PROVISIONS AFFECTING PARTS A AND B OF MEDICARE						
Sequester order through December 31, 1989 (sec. 6201)	−20	0	0	0	0	−20
Medicare as secondary payor (sec. 6202):						
Direct spending	−325	−780	−680	−420	−110	−2,315
Subject to appropriation	25	30	30	20	10	115
Coverage rule for religious order	12	15	20	20	25	92
Payment for ESRD services (sec. 6203)	−45	−85	−110	−135	−165	−540
Physician ownership and referral (sec. 6204)	0	0	0	0	0	0
Costs of nursing and allied health education moratorium fiscal year 1990 only (sec. 6205)	35	0	0	0	0	35

Basic part B premium: 25 percent calendar year 1990 (includes interaction with other part B savings) (sec. 6301)	−330	−465	−490	−520	−550	−2,355
Subtotal Part A and B Savings:						
Outlays	−673	−1,315	−1,260	−1,055	−800	−6,003
Amounts subject to appropriations	25	30	30	20	10	115
Grand total Medicare:						
Outlays	−2,851	−1,902	−1,834	−2,088	−2,244	−10,919
Amounts subject to appropriation	44	88	146	172	177	627

---

[1] Less than 0.5 million.

[2] Estimates for this provision are based on the values in the tables included in the conference report.

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (PUBLIC LAW 101-508)

MEDICARE PROVISIONS

1. Hospital capital payments

Capital payments to Prospective Payment System (PPS) hospitals are reduced 15 percent in fiscal year 1991. In fiscal years 1992 through 1995, total payments to hospitals are reduced by an amount equal to 10 percent of what otherwise would have been paid on a cost basis for capital. Rural Primary Care Hospitals, Essential Access Community Hospitals (EACHs), and sole community hospitals are exempt from the reductions.

2. Prospective payment system (PPS) hospitals

(a) *Hospital payment adjustments.*—The hospital update factors for fiscal years 1991 through 1995 are set as follows: fiscal year 1991—market basket minus 2 percentage points; fiscal year 1992—market basket minus 1.6 percentage points; fiscal year 1993—market basket minus 1.55 percentage points; fiscal years 1994 and 1995—market basket.

(b) *Disproportionate share adjustments.*—The disproportionate share adjustment is increased for urban hospitals with over 100 beds by increasing the multiplier in the formulas on a phased-in basis. For hospitals where the disproportionate patient percentage ("P") is between 15 and 20.2, the formula is: fiscal years 1991, 1992, and 1993—P-15) 0.6+2.5 (effective January 1, 1991); fiscal year 1994 and thereafter—(P-15) 0.65+2.5. For hospitals where the disproportionate patient percentage ("P") is above 20.2, the formula is: fiscal years 1991, 1992, and 1993—(P-20.2) 0.7+5.62; fiscal year 1994—(P-20.2) 0.8+5.88; fiscal year 1995—(P-20.2) 0.825+5.88.

The Secretary of Health and Human Services (the Secretary) is prohibited from restandardizing payment amounts as a result of this provision.

Hospitals which qualify for a disproportionate share adjustment based upon revenue for indigent care received from State and local governments must receive a disproportionate share adjustment of 35 percent.

The disproportionate share adjustment is made permanent. The Secretary is directed not to restandardize payment amounts as a result of the changes in the disproportionate share adjustments made by the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989).

(c) *Updates for rural hospitals.*—The updates for hospitals in rural areas are set as follows: fiscal year 1991—market basket minus 0.7-percentage point; fiscal year 1992—market basket minus 0.6-percentage point; fiscal year 1993—market basket; fiscal year 1994—market basket plus 1.5-percentage points; fiscal year 1995—the percentage increase necessary to close the gap between the rural and the other urban standardized amounts.

(d) *Area wage index.*—Effective January 1, 1991, the Secretary is directed to apply a wage index based solely upon 1988 data without use of corridors to reduce the impact of the use of the new data. The Prospective Payment Assessment Commission (ProPAC) is directed to analyze the impact of variation in occupational mix on the area wage index, and report to the Congress by March, 1991.

(e) *Regional floor.*—The regional floor is extended through fiscal year 1993. The Secretary is directed to collect the necessary data and to create an index for adjusting payments for variations in the costs of nonlabor inputs, and to report to the Congress by June 1, 1993.

(f) *Physician assistant payment offset.*—The provision of the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) authorizing the Secretary to reduce payments to hospitals and skilled nursing facilities to offset charge-based payments for the services of physician assistants is repealed.

(g) *Prospective Payment assessment commission (ProPAC).*—The purpose of ProPAC is defined as advising the Congress on the development of new reimbursement policies and the modification of current reimbursement policies which promote the delivery of efficient, accessible, high-quality health care. The Commission is directed to focus on payment to institutional providers including hospitals, outpatient departments, skilled nursing facilities, ambulatory surgery centers, and others which may be defined in the future.

With respect to PPS, ProPAC is required to recommend a hospital update factor, as well as other proposed changes in current Medicare reimbursement systems, to the Congress by March 1 of each year. The Secretary is still required to make an independent recommendation on the update by March 1. ProPAC is required to submit a report each year by June 1 on Medicare PPS and the health care system. This publication would report generally on issues and problems with the health care system as a whole, and with hospitals and other institutional providers. The requirement for an Office of Technology Assessment (OTA) report to Congress is eliminated. The requirement for the report to Congress on the Secretary's adjustments to PPS is eliminated.

ProPAC is required to analyze Medicaid payments to hospitals and report to the Congress by October 1, 1991, with recommendations relating to requirements under Federal law for payments to hospitals by Medicaid programs.

(h) *Geographic classification review board.*—The application of area wage indices to hospitals newly added to an urban area by a decision of the Board is clarified. The deadline for applications for fiscal year 1992 only is extended to 60 days after the date upon which guidelines for applications have been published. A number of technical corrections are made, including a provision clarifying the Secretary's authority regarding appeal of Board decisions.

3. Hospital DRG payment window

In order to curb further unbundling which has occurred since the introduction of Medicare's hospital Diagnosis Related Group (DRG) payment system, diagnostic services and other services related to a hospital admission provided on the day of the admission, and for up to 72 hours prior to the day of admission, are not separately reimbursable under part B if part A is the primary payer for the admission. The rule applies to diagnostic services provided on or after January 1, 1991, and to other services related to an admission provided on or after October 1, 1991. The new rule does not affect the earlier ban on payment for any services provided 24 hours prior to the date of admission.

4. Payments for graduate medical and nursing education under part A

The Secretary is prohibited from making any recoupments relating to overpayments for the costs of graduate medical education in fiscal year 1991. The recoupments would be made over a 4-year period, with one-quarter of the amount due from each institution payable in each of the 4 fiscal years beginning with 1992.

The clinical education costs of nursing education programs are reimbursable by Medicare under specified circumstances. The Secretary is prohibited from recouping any alleged overpayments relating to costs which will be allowable under this provision, and to the extent such recoupments have already occurred, must refund the money to the hospitals involved. The Secretary is directed to audit the hospitals involved to assure that costs of nursing and allied health programs were properly allocated, and that hospitals did not improperly inflate these costs.

5. PPS-exempt hospitals

PPS-exempt hospitals with costs in excess of the cost limits imposed by the Tax Equity and Fiscal Responsibility Act (TEFRA) would receive 50 percent of the costs in excess of the limit, up to a ceiling of 120 percent of the limit.

The Secretary is directed to develop a new prospective payment methodology for exempt hospitals or to substantially modify the current target-rate system. The Secretary is directed to report to the Committee on Ways and Means and the Senate Committee on Finance his proposals to modify or replace the current system by April 1, 1992. ProPAC is directed to report to the Congress with comments on the proposal by June 1, 1992.

The Contractor Performance and Evaluation standards are amended to require fiscal intermediaries to evaluate and forward applications from exempt hospitals for exceptions and adjustments to the target rates within 60 days of the filing of a completed application, unless further information is required by the intermediary.

The grounds on which the Secretary may grant an appeal for an exception and adjustment to the TEFRA limits are clarified. The grounds include, but are not limited to, a change in applicable technology, medical practice, or case-mix severity which increases costs above the target rate, or a change in wages and wage-related costs in the geographic area of the hospital which exceed the change nationally in wages paid by hospitals.

6. Hospice benefit extension

Coverage for hospice care is authorized for a subsequent period beyond the previous 210-day limit, if the beneficiary is recertified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice program, effective October 1, 1990.

7. Continuation in part A payments through December 31, 1990

Payments to hospitals and hospices are continued at fiscal year 1990 levels for the period October 21, 1990, to December 31, 1990. Fiscal year 1990 standardized amounts, wage indices, regional floor, and the 15 percent reduction in capital payments are maintained for that period. The update in payment for hospices is similarly delayed through December 31, 1990.

8. Miscellaneous and technical provisions relating to part A

OBRA 1990 includes a variety of minor and technical amendments to part A. These amendments (a) extend the waiver of liability for skilled nursing facilities (SNFs) and hospices; (b) clarify hospital obligations with respect to the treatment of emergency conditions through treatment of violations under the existing process relating to hospitals which fail to meet the conditions of participation; (c) require the Inspector General of Health and Human Services (HHS) to study State prohibitions on the employment of physicians; (d) clarify the designation of rural primary care hospitals; (e) provide an update of SNF routine cost limits; (f) clarify the extension of waivers for hospital payment demonstrations, rural hospital demonstrations, and nursing home demonstrations; (g) provide for a special enrollment period in part A for health maintenance organization (HMO) members; (h) make minor and technical amendments in the nursing home reform amendments included in the Omnibus Reconciliation Act of 1987 (OBRA 1987); (i) provide for payment of extended care services in hospital "swing beds"; (j) require the development of a prospective payment system for SNFs; and, (k) provide for a review of hospital regulations with respect to rural hospitals. OBRA 1990 also made a variety of technical amendments.

9. Reduction in payments for certain physician services

(a) *Overpriced procedures.*—OBRA 1990 reduces the 1991 prevailing charges for procedures identified as overpriced in OBRA 1989 by the same amount as the prevailing charges for those procedures were reduced under OBRA 1989. These reductions are effective January 1, 1991.

OBRA 1990 also reduces by 6.5 percent the 1991 prevailing charges for physicians' services that were not included in the first phase of the Harvard Resource-Based Relative Value Scale (RB RVS) study, but are identified by the Physician Payment Review Commission (PhysPRC), as overvalued. Excluded from reduction under this provision are: (1) OBRA 1989 overvalued procedures; (2) radiology, anesthesiology, and pathology services; (3) evaluation and management services; (4) certain services that are subject to a national median cap; and (5) services for which estimates indicate that the national average prevailing charge is overvalued by less than 6.5 percent.

(b) *Radiology services.*—OBRA 1990 reduces the local conversion factors for radiology services (other than portable X-ray services) in 1991 by the lesser of 9.5 percent, or the amount (if any) by which they exceed the 1990 national weighted-average conversion factor, reduced by 13 percent and adjusted for geographic differences in costs.

A special, blended geographic adjustment factor applies in 1991 only, and reductions in local coversion factors are limited to 9 percent in 1992.

The prevailing charges of radiology services not reimbursed under the fee schedule are reduced to the fee schedule amount, effective January 1, 1991. The amount payable for CAT and MRI scans furnished on or after January 1, 1991, is reduced by 10 percent.

OBRA 1990 also extends through 1991 the special payment rules that apply to interventionist radiology and nuclear medicine services in 1990, and it establishes a floor on local conversion factors under the radiology fee schedule.

Carriers are prohibited from applying comparability and inherent reasonableness limitations to services under the radiology fee schedule, effective January 1, 1991. A similar provision becomes effective for other physicians' services on January 1, 1992.

(c) *Anesthesiology services.*—The local prevailing charge conversion factors for physician anesthesia services furnished on or after January 1, 1991, are reduced by the lesser of 15 percent, or the amount (if any) by which they exceed the 1990 weighted national average prevailing-charge conversion factor, reduced by 7 percent and adjusted for geographic variations in costs. A floor is established for local prevailing-charge conversion factors.

In addition, expiring provisions that reduce payments to anesthesiologists for supervising multiple concurrent services by certified registered nurse anesthetists (CRNAs) are extended through 1995.

(d) *Pathology services.*—OBRA 1990 reduces the 1991 prevailing charges for physician anesthesia services by 7 percent below 1990 levels. An exception is made for services furnished through certain independent laboratories. The requirement to implement the pathology fee schedule on January 1, 1991, is repealed. Pathology services will be paid under the RB RVS beginning January 1, 1992.

10. Update in payments for physician services

(a) *Primary care services and other physicians' services.*—The Medicare Economic Index (MEI) increase for primary care services is limited to 2 percent for calendar year 1991. Customary and prevailing charges for all other physicians' services are frozen for the same period, and the 1992 update for all physicians' services is reduced by four-tenths of 1 percent. Under current estimates, this will provide for an update of 2 percent in 1992. The 1991 freeze does not apply to ambulance services. OBRA 1990 raises the floor on prevailing charges for primary care services to 60 percent of the national average prevailing charge for the service involved, and provides for a temporary, 1-year increase in the extra-billing limits for evaluation and management services. For 1991 only, these limits are set at the lower of the physician's 1990 maximum allowable actual charge (MAAC) or 140 percent of the Medicare allowable amount (rather than the 125 percent limit that applies to all other physicians' services in 1991). The limits for 1992 and 1993 remain at 120 percent and 115 percent, respectively, of the Medicare allowable amount.

The existing authority for PhysPRC is amended to provide for consideration of a variety of issues, including: (1) implementation of the RB RVS; (2) further development of the volume performance standard system; (3) payment incentives to increase access to primary care and other services in inner-city and rural areas; (4) the number and types of physicians being trained; (5) physician licensing and certification; (6) medical malpractice; and (7) Administration budget proposals relating to physicians' services under Medicare.

(b) *Physician Medicare volume performance standards (MVPS).*—The Secretary is required to publish separate MVPS for surgical services and all other physicians' services for fiscal year 1991. The standards are set at the baseline rate of growth in expenditures for fiscal year 1991, minus 2 percentage points. The two standards reflect the same rate of growth in volume for surgical and nonsurgical services, and vary only to the extent that legislative and regulatory changes have differential effects on the two categories of services. Publication of the MVPS must occur within 45 days of enactment.

11. Other provisions relating to physician services

(a) *New physicians and practitioners.*—The customary charges of new physicians in 1991 are limited to 80, 85, 90, and 95 percent (of the amount otherwise payable) in the first through fourth years of practice, respectively. Beginning on January 1, 1992, these percentage limits for new physicians in their first through fourth years of practice will apply to the amounts recognized under the RB RVS.

Effective January 1, 1991, similar limits are set for the services of certain nonphysician practitioners, including physician assistants, certified nurse-midwives, qualified psychologists, nurse practitioners, clinical social workers, physical therapists, occupational therapists, respiratory therapists, and certified registered nurse anesthetists.

(b) *Payments for assistant-at-surgery services.*—In most cases, payments for the services of a physician serving as an assistant at surgery are reduced from 20 percent of the primary surgeon's global fee to 20 percent of the intra-operative portion (80 percent) of the global fee. Thus, payments may not exceed 16 percent of the global fee. In the case of procedures for which a physician serves as an assistant at surgery less than 5 percent of the time, no separate payments are made for the services of an assistant at surgery.

(c) *Technical components of certain diagnostic tests.*—Payment for the technical component of certain diagnostic tests is limited to the national median of the reasonable charge (or fee schedule amount) for the service involved. The limits do not apply to clinical laboratory tests, radiology services (such as portable X-ray services), or procedures subject to reduction as overvalued procedures.

(d) *Interpretation of EKGs.*—Effective January 1, 1992, no separate payment will be made for the routine interpretation of an electrocardiogram (EKG) that is performed or ordered in conjunction with a visit or consultation. Payments will continue to be made for the technical component of EKGs performed on an outpatient basis.

12. *Certain administrative changes relating to physician services*

(a) *Reciprocal billing arrangements.*—The conference agreement provides for recognition of certain reciprocal billing arrangements between physicians under specified conditions during continuous periods not in excess of 60 days.

(b) *Study of prepayment medical review screens.*—The Secretary is directed to conduct a study of at least six carriers of the effect of releasing prepayment medical review screen parameters.

(c) *Practicing physicians advisory council.*—OBRA 1990 establishes a Practicing Physicians Advisory Council composed of 15 physicians in active practice. The Council will review and comment on proposed regulations and carrier manual instructions relating to physicians' services.

(d) *Study of aggregation rule relating to part B appeals.*—The Secretary is directed to conduct a study in at least four carrier areas of the effect of permitting certain changes in the aggregation rule with respect to claims under appeal.

13. *Screens for physician visits in rehabilitation hospitals*

The Secretary is required to issue guidelines to assure a uniform level of scrutiny by carriers in cases in which the prepayment utilization screen parameters established under section 4085 of OBRA 1987 have been exceeded.

14. *Study of regional variations in impact of Medicare physician payment reform*

The Secretary is required to study the factors that may cause certain geographic areas to experience disproportionately large reductions in payments for physician's services under the RB RVS for physicians' services that become effective in 1992, and to report to the Congress, not later than July 1, 1992, on appropriate adjustments to the fee schedule to compensate for these reductions and to ensure continued access to health care for Medicare beneficiaries in those areas.

15. *Statewide fee schedule areas for physicians' services*

The Secretary is required to consolidate the existing payment localities for physicians' services in Oklahoma into a single payment locality if certain conditions are met. The consolidation will be implemented in a budget-neutral manner and will become effective on January 1, 1992. A similar provision is also included for Nebraska.

16. *Payments for hospital outpatient services*

(a) *Capital.*—Capital payments for hospital outpatient services are reduced 15 percent from cost in fiscal year 1991, and 10 percent in each of the four subsequent fiscal years, effective for portions of cost reporting periods occurring after October 1, 1990. Sole community, EACH and RPCH hospitals are exempt from the reduction.

(b) *Outpatient services on a cost-related basis.*—Payments for services on a cost related basis are reimbursed at 94.2 percent of costs, effective for portions of cost reporting periods occurring during fiscal years 1991 through 1995. Sole community hospitals, essential access community hospitals (EACH) and rural primary care hospitals (RPCH) are exempt from the reduction.

The Secretary is directed to provide for the development of a proposal for paying for hospital outpatient services under a prospective payment system. In developing this proposal, the Secretary must consider policies which provide appropriate limits on growth, adjustments to account for changes in types of patients treated, volume, technology, and medical practice, provide incentives for hospitals to control costs, and other issues. The Secretary must also consider whether payments for the same service should vary by the type of facility in which the service is provided, such as between freestanding facilities and hospital-based outpatient departments.

The Secretary must submit a proposal to the Congress by September 1, 1991, and ProPAC must analyze and comment on the report by March 1, 1992.

(c) *Payments for ambulatory surgery and radiology.*—Ambulatory surgical services and radiology services in hospital outpatient departments are subject to aggregate cost limits based on a 42/58 blend of the hospital's own costs and the rates for the same services provided in freestanding facilities, effective January 1, 1991. The special limit for ambulatory surgery provided in eye specialty hospitals and eye and ear specialty hospitals is extended through 1995.

In determining the payment rates for intraocular lens (IOLs) furnished during or subsequent to cataract surgery, the Secretary must recognize an allowance of $200 per IOL, effective on enactment through December 31, 1992.

17. Durable medical equipment (DME)

(a) *Overpriced DME.*—OBRA 1990 reduces for transcutaneous electrical nerve stimulation (TENS) devices by 15 percent, effective January 1, 1990. This reduction is in addition to the 15-percent reduction in payments for these devices that was mandated by OBRA 1989. Coverage and payment for seatlift chairs furnished in 1991 and thereafter is limited to the lift mechanism and does not include the chair.

(b) *National limits on fees.*—Regional limits on fees are repealed. National upper- and lower-fee limits are established for all categories of DME except for customized equipment, and local fees above or below these limits are phased to the limiting amount over a 3-year period.

The upper limits for an item are the weighted average of the fee schedule amounts that apply in 1991. In 1991 and 1992, payments are capped at a blend of the local fee schedule amount and the national limit. In 1991, the blend is based on 67 percent of the local fee and 33 percent of the national limit. In 1992, the blend will be based on 33 percent of the local fee and 67 percent of the national limit. In 1993, the fee schedule amounts in areas that exceed the upper limit are set at the national limit.

National fee "floors" for an item are set at 85 percent of the national upper limits in 1991. In 1991 and 1992, payments are subject to a lower limit equal to a blend of the local fee schedule amount and the national fee floor. In 1991, the blend is based on 67 percent of the local fee and 33 percent of the national floor. In 1992, the blend is based on 33 percent of the local fee and 67 percent of the national floor. In 1993, the fee schedule amounts in areas that are below the national floor is set at the floor.

Fees in areas that are between the national average and 85 percent of the average are not affected by this provision.

(c) *Rental cap items.*—Payments for the rental of DME rental-cap items are based on a fee schedule equal to 10 percent of the purchase price for the first 3 months of rental, and 7.5 percent of the purchase price for the 4th through 15th months of rental.

Purchase prices for rental cap items are reduced by the percentage difference between the average submitted charge and the average allowed charge for a base period (the final nine months of 1988).

Patients must be given the opportunity to purchase rental equipment in the 10th month of rental. If the patient chooses the purchase option, payments will continue through the 13th month. In the case of a power-driven wheelchair, the beneficiary is permitted to purchase the item at the beginning of the period of medical need.

Noncustomized motorized wheelchairs are recategorized into the rental cap category of equipment. The option for treating wheelchairs as "customized" remains unchanged.

If the Secretary does not issue regulations defining "customized" wheelchairs by January 1, 1992, a statutory definition will become effective.

(d) *Oxygen retesting.*—Beneficiaries that qualify for oxygen therapy for an initial period of three months will be retested (based upon criteria established by the Secretary) to confirm their continued need for oxygen use, prior to continuing payments for oxygen therapy beyond the initial 3 months.

(e) *Useful lifetime of rental equipment.*—A reasonable useful lifetime of rental and frequently serviced items is established. The useful lifetime is five years, unless the Secretary finds, based on program experience, that a longer or shorter period is appropriate for an item. After an item's useful lifetime is reached during a continuous period of medical necessity, the Secretary must provide for a new cycle of rental payments. Carriers are permitted to begin an earlier cycle of new rental payments for equipment that is lost or irreparably damaged.

(f) *DME update.*—The update for DME is reduced by 1 percent in 1991 and 1992.

(g) *Enteral and parenteral nutrients, equipment, and supplies.*—Payment levels for enteral and parenteral nutrients, equipment, and supplies are not updated for 1991.

(h) *Administrative procedures.*—Suppliers are prohibited from distributing completed or partially completed Medicare medical-necessity forms to physicians or beneficiaries. Suppliers who distribute such forms are subject to civil monetary penalties.

For customized equipment and equipment designated by the Secretary as frequently subject to unnecessary utilization, suppliers must obtain prior approval of the item from a carrier in a form determined by the Secretary. Items subject to this provision include seatlift mechanisms, TENS equipment, power-driven scooters, and such other items of DME as determined appropriate by the Secretary.

(i) *Orthotics and prosthetics.*—Payments for orthotics and prosthetics are recodified in a separate subsection of law. The current requirements relating to regional fees are delayed by 1 year. Otherwise, payments are made on the same basis as under previous law.

Payments for orthotic and prosthetic devices are frozen at 1990 levels.

The GAO is directed to conduct a study of payments for orthotic and prosthetic items and services under Medicare.

In addition, the Secretary is prohibited from issuing regulations changing coverage for conventional eyewear furnished subsequent to cataract surgery with implantation of an IOL, and coverage is clarified to include one pair of eyeglasses or contact lenses following each such surgery. There is no change in coverage of special cataract eyeglasses or cataract contact lenses.

18. Clinical laboratory services

(a) *Laboratory fee schedule update.*—The update for clinical laboratory services is limited to 2 percent for each of the years 1991, 1992 and 1993.

(b) *Payments for laboratory services.*—Effective for services furnished on or after January 1, 1991, the national limit on clinical laboratory fee schedules is reduced from 93 percent to 88 percent of the median of local fee schedules. The new national limit is based on updated fee schedule amounts.

19. Coverage of nurse practitioners in rural areas

OBRA 1990 includes coverage of, and direct payment for, the services of nurse practitioners and clinical nurse specialists in rural areas. Payment for such services are made only on the basis of an assignment.

20. Coverage of injectable drugs for treatment of osteoporosis

Coverage and payment is authorized for an injectable drug for the treatment of bone fractures of individuals who have a diagnosis of postmenopausal osteoporosis, and who meet certain other conditions, through 1995. The Secretary must study the impact of this coverage, and report any findings and recommendations to Congress by October 1, 1994.

21. Separate payment under part B for the services of certain health practitioners

OBRA 1990 includes certain conforming changes with respect to the coverage of services provided to hospital inpatients by psychologists and other practitioners.

22. Reductions in payments under part B during the final two months of 1990

Program payments under part B (except to HMOs) are reduced by 2 percent for services furnished on or after November 1, 1990, and on or before December 31,1990. Beneficiary liability for part B cost-sharing is unaffected by this reduction in the same manner as under a sequester order.

23. Payments for graduate medical and nursing education under part B

OBRA 1990 prohibits the recoupment of overpayments for the costs of graduate medical education in fiscal year 1991, and provides for a phased recoupment over the subsequent 4-year period. In addition, certain changes are made in the policy for payment of nursing education costs, and recoupment of alleged overpayments is prohibited.

24. Certified registered nurse anesthetists (CRNAs)

Payments for services of certified registered nurse anesthetists are revised and phased in over a 6-year period. Payments for nonmedically directed anesthesia services must, by 1996, be consistent with payments estimated for similar services provided by physicians under the Medicare fee schedule. Payments for medically directed CRNA services must also be phased in so that payments in 1995 are 70 percent of the Medicare fee schedule amount for anesthesia services. The conversion factors for CRNAs are subject to a cap in each locality equal to the conversion factor for physician anesthesia services.

25. Community health centers and rural health clinics

OBRA 1990 clarifies the basis on which payments can be made to community and migrant health centers, and to programs for the homeless, effective October 1, 1991. Payments are based on an all-inclusive rate. Provisions effecting rural health clinics are amended to expedite the certification process, permit waiver of staffing requirements, and provide for uniform screening guidelines. The General Accounting Office (GAO) is directed to conduct a study of whether physicians practicing in community and migrant health centers are able to obtain admitting privileges at local hospitals.

26. Partial hospitalization in community mental health centers

Coverage of partial hospitalization services is extended to community mental health centers that meet applicable licensing or certification requirements of the state in which they are located.

27. Coverage of mammography screening

Medicare coverage is extended to include mammography screening. The benefit is similar to the benefit enacted in Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, and is effective for services provided on or after January 1, 1991.

For women over 65, biennial screening is covered with the limitation that 23 months must have elapsed since the last screening. For disabled women, screening is not covered for individuals under the age of 35; a baseline screening is covered for those between the ages of 35 and 40; biennial screenings are covered for those who are not at high risk between the ages of 40 and 49 (provided 23 months have elapsed since the last screening); and annual screenings are covered for high risk women between 40 and 49 and all women between 50 and 64 (provided 11 months have elapsed since the last screening).

Payment is equal to 80 percent of the *least* of: (1) the actual charge; (2) the radiology fee schedule amount (for both the professional and technical components of screening mammography); or (3) a specified limit of $55 in 1991, updated in the same manner as the MEI between 1991 and 1992, and in subsequent years.

On unassigned claims, the actual charges of the physicians are subject to a limit of 125 percent in 1991, 120 percent in 1992 and 115 percent of the payment amount in 1993.

28. Miscellaneous and technical provisions relating to part B

(a) *Prevention demonstrations.*—The Medicare prevention demonstrations are extended for one year, with a $1.6 million increase in authorized funds.

(b) *Alzheimer's disease demonstration projects.*—The Alzheimer's disease demonstration projects are extended to 4 years, with a $15 million increase in authorized funds.

(c) *Disclosure of ownership.*—The requirements for disclosure of certain ownership information by suppliers and certain other entities providing services under part B are clarified.

29. End stage renal disease (ESRD)

(a) *Payments to dialysis facilities.*—The Secretary is required to maintain the rate for hospital-based and freestanding facilities at the rate in effect September 30, 1989, without regard to reductions imposed by OBRA 1900. Effective January 1, 1991, the rate increases by $1.

ProPAC is required to study the cost, services and profits associated with various dialysis modalities provided to ESRD patients and make recommendations to Congress regarding the method and the levels at which payments should be established for dialysis services. The Commission must report its findings no later than June 1, 1992.

(b) *Self-administration of erythropoietin (EPO).*—Effective July 1, 1991, coverage for EPO and items related to its administration is allowed for home renal-dialysis patients who are competent to use the drug without medical or other supervision, subject to the methods and standards established by the Secretary through regulation for the safe and effective use of the drug.

(c) *Payments for EPO.*—Payments for EPO are revised and are based on 1,000-unit increments. Beginning January 1, 1991, the Secretary must make payments of no more than $11 per 1,000 units, rounded to the nearest 100 units. In subsequent years, the maximum amount payable is indexed to the GNP-deflator.

(d) *Demonstration for staff-assisted home hemodialysis.*—The Secretary is directed to establish a 3-year demonstration project to evaluate whether staff-assisted home hemodialysis services are cost-effective and safe for qualified ESRD beneficiaries. Individuals currently receiving staff assistance under the Secretary's experimental authority are continued under that authority, subject to the terms and conditions otherwise in effect.

30. Extension of secondary payer provisions

(a) *Extension of transfer of data.*—The provision originally included in OBRA 1989 is extended through September 30, 1995.

(b) *Extension of application to disabled beneficiaries.*—The application of secondary payer provisions to the disabled is extended through October 1, 1995.

(c) *Extension of the provision applying to ESRD.*—The period during which employer-based health coverage is the primary payer for ESRD patients is extended to a true 18-month period. The Comptroller General is required to study and report on the impact of the extension on individuals eligible for Medicare on the basis of ESRD.

31. Health maintenance organizations (HMOs)

(a) *Regulation of incentive payments to physicians.*—The Secretary cannot enter into a contract with an HMO unless certain conditions regarding the physician incentive payment plan were met. In order for the Secretary to assess the physician incentive plan of the HMO, the HMO is required to provide descriptive information, satisfactory to the Secretary, on the physician incentive plans it employs for services to Medicare beneficiaries. The physician incentive plan employed by the HMO cannot provide specific payments directly or indirectly to physicians as an inducement to withhold or limit medically necessary services to a specific patient. Physician incentive plans must meet two criteria.

The HMO's physician-incentive plan cannot place physicians at substantial financial risk (as determined by the Secretary) for services not provided by the physician, or by the physician group, unless the HMO: (1) provides adequate and appropriate stop-loss protection for the physician or the physician group, including assuring that the stop-loss protection is appropriate to the size of the specific physician group and patient panel, as determined based upon standards developed by the Secretary; and (2) has conducted periodic surveys of enrolled beneficiaries to determine, among other things, the degree of beneficiary satisfaction with access and quality.

(b) *Requirements with respect to actuarial equivalence of AAPCC.*—The Secretary is required to revise the current methodolgy used to establish the adjusted average per capita cost and report to Congress with a proposal by January 1, 1992. The Secretary is required to consult with the American Academy of Actuaries with respect to the proposed payment methodology. GAO is required to review the Secretary's proposal by May 1, 1992.

(c) *Application of national coverage decisions.*—Changes in Medicare benefits, known as "National Coverage Decisions," promulgated by the Secretary from time to time throughout the year, which significantly change the cost of providing benefits to beneficiaries, cannot apply to risk contracts with HMOs in any contract year unless the costs of the change in coverage were included in the Secretary's annual notice of per capita rates of payment for beneficiaries enrolled in HMOs. Enrolled beneficiaries will receive services covered under new decisions promulgated after the required notices on a fee-for-service basis.

(d) *Limits on payments for out-of-plan services under part B.*—The limit on payment under part B for out-of-plan and emergency physician services provided to beneficiaries enrolled in an HMO is extended to all out-of-plan and emergency services under part B, including dialysis services.

(e) *Retroactive enrollment.*—Payments on behalf of beneficiaries enrolling in a Medicare risk-contract HMO, who held prior membership in that HMO under a employer group contract, are permitted, effective as of the date of enrollment for up to 3 months.

(f) *Study of chiropractic services.*—The Secretary is required to study the extent to which HMOs make chiropractic services available to enrollees.

(g) *Prohibiting certain employer maketing techniques.*—It is unlawful for an employer or other entity to offer any financial incentive not to enroll in a employee-sponsored group health plan to an individual who is a Medicare beneficiary, unless the incentive is available to all individuals eligible for membership in the group health plan.

32. Peer review organizations (PROs)

OBRA 1990 makes certain changes in the PRO program, including: (a) clarification of the willing and able standard; (b) provision for the exchange of information and coordination of review activities between PROs and Medicare carriers; (c) provision for the exchange of information between PROs and State licensing boards, including requiring the Secretary to notify State licensing boards when a physician is excluded from Medicare; (d) assurance of the confidentiality of PRO deliberations; (e) clarification the limits on liability for PROs; and (f) increase in the involvement of optometrists and podiatrists in the review of services provided by them.

33. Patient self-determination

Hospitals, skilled nursing facilities, hospices, home health agencies, and HMOs are required to: (a) provide each patient with written information concerning the relevant State law with respect to advance directives or "living wills," including durable powers of attorney; (b) inquire whether an adult patient has formulated an advance directive; and (c) document whether an advance directive exists in the patient's medical record.

34. Miscellaneous and technical provisions relating to parts A and B

OBRA 1990 makes a variety of minor and technical amendments affecting both part A and part B of Medicare. These include provisions which clarify hospital and physician obligations with respect to emergency medical conditions by providing that: (a) negligent violations may lead to civil monetary penalties; (b) flagrant and repeated violations may lead to exclusion from the Medicare program; and (c) the inspector general must consult with the relevant PRO to assist in determining whether an emergency medical condition existed and whether a patient's condition was not stable.

Also included are provisions which: (a) prohibit issuance of regulations which save more than $50 million prior to the beginning of fiscal years; (b) prohibit slowing down or speeding up of Medicare payments; (c) require development of a prospective payment system for home health agencies; (d) adjust the home health wage index; (e) extend waivers for Social Health Maintenance Organizations and expand the program to four additional sites; (f) clarify definitions and requirements relating to physician ownership and referral; (g) reestablish case management demonstration projects; (h) provide for delegation of certain civil enforcement powers to the Inspector General; and (i) prohibit imposition of user fees for hospital, nursing home, and other facility survey and certification.

35. Part B premium

The part B premium is set as follows: $29.90 in 1991, $31.80 in 1992 $36.60 in 1993, $41.10 in 1994 and $46.10 in 1995. The premiums reflect current estimates of the level necessary for premiums to cover 25 percent of program costs through 1995.

36. Part B deductible

The part B deductible is set at $100 in 1991, and in subsequent years.

37. Standards for Medicare supplemental insurance (Medigap)

(a) *Simplification of policies.*—Benefit options must be simplified to provide for a core group of benefits, and up to a maximum of nine other groups of defined medigap packages. The defined core group of benefits must be common to all defined medigap benefit packages. All medigap insurers are required to offer the core group of benefits.

New or innovative benefits could be offered in addition to the benefits provided in a policy that otherwise complies with the applicable standards. Such new or innovative benefits, if approved by the State (if issued in a State with an approved program) or by the Secretary, might include benefits that are not otherwise available and are cost-effective.

The Secretary is authorized to waive the simplification standards for any State with an alterantive simplification program in place on the date of enactment.

Noncompliance with simplification standards is subject to a civil money penalty not to exceed $25,000.

(b) *Uniform policy description.*—Insurers are required to provide an outline of coverage using uniform language and format, to facilitate comparisons among medigap policies and comparisons with Medicare benefits. The outline of coverage must be on a standard form approved by the State regulatory program or the Secretary, consistent with standards developed by the National Association of Insurance Commissioners (NAIC) or the Secretary.

(c) *Prevention of duplicate medigap coverage.*—It is unlawful for a medigap policy to be issued unless the seller obtains from the applicant a written, signed statement stating what type of health insurance the applicant has, the source of the health insurance, and whether the applicant is entitled to Medicaid. The written statement must be accompanied by a written acknowledgement, signed by the seller. The statement must be on a form that includes specified language regarding duplicative benefits, and must indicate if counseling services are available in the State.

It is unlawful to sell or issue a medigap policy, or health insurance that duplicates a medigap policy to an individual who has a medigap policy, unless the individual indicates in writing that the policy replaces an existing policy which will be terminated.

The direct sale of medigap policies to Medicaid beneficiaries is prohibited. There is an exception in cases where states pay the medigap premiums for Medicaid beneficiaries. Medigap insurers will, for a 24-month period, suspend premium payments paid by beneficiaries during periods of Medicaid eligibility.

Noncompliance with these provisions is subject to civil money penalties.

(d) *Loss ratios.*—Minimum loss ratios are increased to 65 percent for individual sold medigap policies, and are established at 75 percent for group medigap policies. A methodology for uniform calculation of actual and projected loss ratios, with uniform reporting requirements, must be developed by the NAIC and must be used by all medigap insurers to submit loss ratio levels to the State regulatory entity, or to the Secretary if a policy is sold in a State without an approved regulatory program.

Policy issuers are required to provide a refund or a credit against future premiums to assure that loss ratios comply with requirements.

Noncompliance with loss ratio requirements is subject to a civil money penalty not to exceed $25,000 for each violation.

(e) *Renewability, replacement and coverage continuation, preexisting condition and medical underwriting limitations.*—Medigap policies must be guaranteed renewable. The issuer is not permitted to cancel or refuse to renew the policy solely on the grounds of the health status of the policyholder. The issuer may only cancel or nonrenew the policy for reason of nonpayment of premium or material misrepresentation.

If the medigap policy is terminated by the group policyholder and is not replaced the issuer is required to offer certificate-holders an individual medigap policy which provides for the contunuation of benefits contained in the group policy. If a group medigap policy is replaced by another group medigap policy purchased by the same policyholder, the succeeding issuer must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy must not result in any exclusion for preexisting conditions that were covered under the group being replaced.

Medigap insurers are required to offer coverage to individuals, regardless of medical history, for a 6-month period after an applicant turns 65, or for the working-aged, for a 6-month period when they first enroll in Medicare part B. Insurers must be prohibited from discriminating in the price of the policy based upon the medical or health status of the policyholder.

Medigap insurers that violate provisions pertaining to medical underwriting are subject to a civil monetary penalty not to exceed $5,000 for each policy in violation.

(f) *Premium increases.*—To have an approved regulatory program, States are required to have a process for approving or disapproving proposed premium increases, and to establish a policy for holding public hearings prior to approval of premium increases.

(g) *Enforcement of standards.*—No policy may be sold or issued unless the policy is sold or issued in a State with an approved regulatory program, or is certified directly by the Secretary.

The Supplemental Health Insurance Panel is abolished, and the Secretary, rather than the Panel, is required to review State regulatory programs.

States are required to report to the Secretary on the implementation and enforcement of standards at intervals established by the Secretary. The report to the Secretary must include information on loss ratios, the frequency and types of instances in which policies approved by the State fail to meet the standards, actions taken by the State to bring such policies under compliance, and information regarding State programs to implement consumer protection provisions.

If the Secretary finds that a State program no longer meets the standards, the Secretary must provide the State an opportunity to adopt a plan of correction that will permit the State to continue to meet the standards. If the Secretary makes a final determination that the State program fails to meet the standards, the program must no longer be approved. In such a case, policies sold in a State without an approved program must be certified by the Secretary.

Issuers of nonapproved policies are subject to a civil money penalty of up to $25,000.

(h) *Promulgation of regulations.*—If within 9 months after the date of enactment, the NAIC promulgates standards to implement the amendments made by this Act, then the Standards will be applied in each State for policies to be approved. If the NAIC does not promulgate such standards, then the Secretary is required to pomulgate such standards not later than 18 months after date of enactment.

In general, the standards adopted by States apply by the earlier of the date the State adopts the NAIC standards, or 1 year after the NAIC or the Secretary first adopts the standards.

(i) *State approval of policies sold in States.*—All policies sold in a State, including policies sold through the mail, must be approved by the State in which the policy is issued on or after July 1, 1991.

(j) *Counseling.*—The Secretary is required to establish a health insurance advisory service program to assist Medicare eligible individuals with the receipt of services under Medicare, Medicaid and other health insurance programs.

In addition, the Secretary is required to make grants to States to support counseling programs.

(k) *Medicare select.*—The Secretary is authorized to establish a 3-year demonstration project in up to 15 States which will allow benefits under a lower cost policy to be restricted to items and services furnished by certain providers (or reduced benefits to be provided when items or services are furnished by other providers), if a policy otherwise complies with medigap standards and certain quality assurance standards.

TABLE 46.—ESTIMATED BUDGET IMPACT OF MEDICARE RECONCILIAITON PROVISIONS (OBRA 1990)

[Estimates from CBO summer 1990 baseline by fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	5-year total
Provisions relating only to part A						
4001 Payments for capital-related costs of inpatient hospital services	−810	−720	−760	−840	−920	−4,050
4002 Prospective payment hospitals.[1]	−385	−1,335	−2,240	−2,445	−2,485	−8,890
4003 Expansion of DRG payment window	−45	−110	−120	−135	−145	−555
4004 Payments for medical education costs	205	220	115	−15	−45	480
4005 PPS-exempt hospitals	0	20	35	40	45	140
4006 Hospice benefit extension	*	*	1	1	1	4
4007 Freeze in payments under part A through December 31	−495	0	0	0	0	−495
4008 Miscellaneous and technical provisions relating to part A	35	45	50	55	60	245
Subtotal part A	−1,495	−1,880	−2,919	−3,339	−3,489	−13,122
Provisions relating to part B						
4101 Certain overvalued procedures	−370	−605	−670	−745	−825	−3,215
4102 Radiology services [2]	−135	−230	−255	−290	−330	−1,240
4103 Anesthesia services [2]	−25	−40	−45	−50	−60	−220
4104 Physician pathology services	−5	−10	−15	−15	−15	−60
4105 Update for physicians' services	−305	−570	−655	−725	−805	−3,060
4106 New physicians and other new health care practitioners	−55	−105	−125	−140	−155	−580
4107 Assistants at surgery	−30	−50	−55	−60	−65	−260
4108 Technical components of certain diagnostic tests [2]	−20	−40	−40	−50	−50	−200
4109 Interpretation of electrocardiograms	0	−110	−185	−205	−225	−725
4110 Reciprocal billing arrangements	0	0	0	0	0	0
4111 Study of prepayment medical review screens	0	0	0	0	0	0
4112 Practicing physicians advisory council	0	0	0	0	0	0
4113 Study of aggregation rule for claims for similar physicians' services	0	0	0	0	0	0

TABLE 46.—ESTIMATED BUDGET IMPACT OF MEDICARE RECONCILIAITON PROVISIONS (OBRA 1990)—Continued

[Estimates from CBO summer 1990 baseline by fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	5-year total
4114 Utilization screens for physician visits in rehabilitation hospitals	0	0	0	0	0	0
4115 Study of regional variations in impact of medicare physician payment reform	0	0	0	0	0	0
4116 Limitation on beneficiary liability	0	0	0	0	0	0
4117 Statewide fee schedule areas for physicians' services	0	0	0	0	0	0
4118 Technical corrections	0	0	0	0	0	0
4151 Payments for hospital outpatient services	−355	−450	−520	−605	−710	−2,640
4152 Durable medical equipment [2]	−205	−375	−460	−520	−580	−2,140
4153 Provisions relating to orthotics and prosthetics	−35	−60	−65	−70	−75	−305
4154 Clinical diagnostic laboratory tests	−90	−185	−270	−325	−365	−1,235
4155 Coverage of nurse practitioners in rural areas	3	4	4	5	5	21
4156 Coverage of injectable drugs for treatment of osteoporosis	8	15	15	15	20	73
4157 Separate payment under part B for services of certain health practitioners	*	*	1	1	1	3
4158 Reduction in part B payments under part B during final 2 months of 1990	−95	0	0	0	0	−95
4159 Payments for medical education costs	25	30	15	0	−5	65
4160 Certified registered nurse anesthetists	45	70	80	90	110	395
4161 Community health centers and rural health clinics	0	35	40	45	50	170
4162 Partial hospitalization in community mental health centers	0	10	15	15	20	60
4163 Coverage of screening mammography [1]	140	235	265	290	320	1,250
4164 Miscellaneous and technical provisions relating to part B	0	0	0	0	0	0
Subtotal part B	−1,504	−2,431	−2,925	−3,339	−3,739	−13,938
Provisions relating to parts A and B						
4201 Provisions relating to end stage renal disease	−5	0	5	10	15	25
4202 Staff-assisted home dialysis demonstration project	4	4	3	2	1	14
4203 Extension of secondary payor provisions	−50	−825	−1,370	−1,780	−2,060	−6,085

4204 Health maintenance organizations	0	0	0	0	0	0
4205 Peer review organizations	0	0	0	0	0	0
4206 Medicare provider agreements assuring a patient's right to participate in and direct health care decisions affecting the patient	0	0	0	0	0	0
4207 Miscellaneous and technical provisions relating to parts A and B:						
(Direct spending)	15	20	25	30	30	120
(Subject to appropriation)	4	2	1	0	0	7
Subtotal parts A and B						
(Direct spending)	−36	−801	−1,337	−1,738	−2,014	−5,926
(Subject to appropriation)	4	2	1	0	0	7
Provisions relating to part B premium and deductible						
4301 Part B premium						
Medicare savings	0	−180	−1270	−2580	−4050	−8080
Medicaid offset	0	15	100	200	310	625
Net savings	0	−165	−1170	−2380	−3740	−7455
4302 Part B deductible						
Medicare savings	−380	−595	−610	−620	−635	−2840
Medicaid offset	30	50	50	50	50	230
Net Savings	−350	−545	−560	−570	−585	−2610
Subtotal part B premium and deductible	−350	−710	−1730	−2950	−4325	−10065
Medicare supplemental insurance policies						
4359 Health insurance advisory services for medicare beneficiaries:						
(Subject to appropriation)	4	5	5	5	5	24
4360 Health insurace information, counseling, and assistance grants:						
(Subject to appropriation)	9	10	10	2	0	31
4361 Medicare and medigap information by telphone:						
(Subject to appropriation)	9	10	10	10	10	49
Subtotal Medicare supplemental policies	22	25	25	17	15	104

TABLE 46.—ESTIMATED BUDGET IMPACT OF MEDICARE RECONCILIAITON PROVISIONS (OBRA 1990)—Continued

[Estimates from CBO summer 1990 baseline by fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	5-year total
Summary						
Direct spending:						
Part A	−1495	−1880	−2919	−3339	−3489	−13122
Part B	−1504	−2431	−2925	−3339	−3739	−13938
Parts A and B	−36	−801	−1337	−1738	−2014	−5926
Part B premium and deductible	−350	−710	−1730	−2950	−4325	−10065
Subtotal direct spending	−3385	−5822	−8911	−11366	−13567	−43051
Amount subject to appropriations action:						
Parts A and B	4	2	1	0	0	7
Medicare supplemental policies	22	25	25	17	15	104
Subtotal subject to appropriation	26	27	26	17	15	111

---

[1] The conferees agreed to offset the costs of the screening mammography (section 4163) and regional floor (section 4002 (e)) provisions through deficit reduction measures under the jurisdiction of the House Ways and Means and Senate Finance Committees other than reductions in spending under the Medicare program. The cost of these provisions are not reflected in the overall totals. The 5-year cost of the regional floor provision is $365 million.

[2] Estimates of these provisions reflect the intent of Congress and HCFA implementation.

REPORTS AND STUDIES

The following is a list (as of March 31, 1991) of studies and reports required by law which are either past due or are to be concluded in the next 5 years.

Topic	Due date
Secretary of Health and Human Services to conduct and promptly complete all studies and experiments required under present law which pertain to the use of, and reimbursement for, nutritional therapy; and that the Secretary transmit a full and complete report with respect to each study and experiment. (H.Rept. 97-208 (Conference Report, p. 946.), Public Law 97-35; H.R. 3982.) (Aug. 4, 1984. Letter from HHS stating delay.)	January 1, 1983
Comptroller General of the United States shall report to Congress on the appropriateness of fee schedules under sec. 1833(h) of the Social Security Act—clinical diagnostic laboratory tests—and their impact on the volume and quality of such tests. (Sec. 2303(i) (1) and (3), Public Law 98-369; H.R. 4170.)	January 1, 1987
Secretary of Health and Human Services after consultation with the Physician Payment Review Commission, shall develop recommendations and guidelines, and report to Congress, respecting surgical procedures for which an assistant at surgery is generally not medically necessary and the circumstances under which the use of an assistant at surgery is generally appropriate but should be subject to prior approval of an appropriate entity. (Sec. 9307(d), Public Law 99-272; H.R. 3128.)	January 1, 1987
Secretary of Health and Human Services shall conduct a study and report to Congress information on the frequency and distribution (by type of provider) of denials of bills for payment under title XVIII of the Social Security Act for extended care services, home health services, and hospice care. (Sec. 9305(g)(2), Public Law 99-509; H.R. 5300.)	March 31, 1987
Secretary of Health and Human Services shall report to the House Committees on Ways and Means and Energy and Commerce, and the Senate Committee on Finance on whether the Medicare payment methodology for direct graduate medical education costs should be revised to provide for greater uniformity in the approved FTE resident amounts and if so, how such revisions should be implemented. (Sec. 9202(e), Public Law 99-272; H.R. 3128.)	December 31, 1987
Secretary of Health and Human Services shall conduct a study and report to Congress information on the frequency and distribution (by tupe of provider) of denials of bills for payment under title XVIII of the Social Security Act for extended care services, home health services, and hospice care. (Sec. 9305(g)(2), Public Law 99-509; H.R. 5300.)	March 31, 1988
Secretary of Health and Human Services shall arrange for a study to develop a strategy for quality review and assurance under title XVIII of the Social Security Act. (Sec. 9313(d), Public Law 99-509; H.R. 5300.)	October 21, 1988
Secretary of Health and Human Services shall conduct a study and report to Congress on the adequacy of review standards for Medicare conditions of participation for assuring quality of inpatient hospital services. (Sec. 9305(d), Public Law 99-509; H.R. 5300.)	October 21, 1988
Secretary of Health and Human Services shall provide for a demonstration project to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare and Medicaid programs, and submit an interim report to Congress. (Sec. 4027(c), Public Law 100-203; H.R. 3545.)	December 22, 1988

Topic	Due date
Secretary of Health and Human Services shall report to Congress on the development of a uniform needs assessment instrument(s) that evaluates the functional capacity of a beneficiary, and requirements to meet health care needs which can be used by discharge planner, health care providers and intermediaries in evaluating the beneficiary's need for posthospital health care or services. (Sec. 9305(h), Public Law 99-509; H.R. 5300.)	January 1, 1989
Secretary of Health and Human Services shall report to Congress on alternative methods for reimbursement relative to adjustment of hospital wage indices for Fiscal Year 1989. (Sec. 8403(b), Public Law 100-647; H.R. 4333.)	January 10, 1989
Secretary of Health and Human Services to study and report to Congress on payment for chemotherapy in physicians' offices. (Sec. 4055(d)(2), Public Law 100-203; H.R. 3545.)	April 1, 1989
Secretary of Health and Human Services shall submit a final report to Congress on the results of the implementation of provisions mandating 100 percent peer review for certain surgical procedures. (Sec. 9401(b), Public Law 99-272; H.R. 3128.)	April 7, 1989
Secretary of Health and Human Services shall study and report to the Committees on Ways and Means and Energy and Commerce, and the Senate Committee on Finance on reimbursement for specimen collection and transportation and personnel costs related to trip fees for clinical laboratories. (Sec. 8421(c), Public Law 100-647; H.R. 4333.)	May 1, 1989
Secretary of Health and Human Services shall review and submit a report to the Committees on Energy and Commerce and Ways and Means and the Senate Finance Committee on reimbursement for blood clotting factor for hemophilia patients. (Sec. 6142, Public Law 101-239; H.R. 3299.)	June 19, 1989
Secretary of Health and Human Services shall study and report to Congress on the information collected in the survey of current adult day care services. Based on such information the Secretary shall make recommendations concerning appropriate standards for coverage of adult day care services under Medicare, including defining chronically dependent individuals, defining services included in adult day care services, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism. (Sec. 208(c), Public Law 100-360; H.R. 2470.)	June 30, 1989
Advisory Committee on Medicare Home Health Claims shall study and report to the Committees on Ways and Means and Energy and Commerce, and the Committee on Finance of the Senate on its findings and recommendations for changes in the regulations under title XVIII of the Social Security Act as they relate to denial of claims for home health services. (Sec. 427(d), Public Law 100-360; H.R. 2470.)	June 30, 1989
General Accounting Office shall conduct a study and report to Congress on the level of the fee schedules established for clinical diagnostic laboratory services to determine, based on the costs, and revenues received for, such tests the appropriateness of such schedules. (Sec. 4064(b)(4), Public Law 100-203; H.R. 3545.)	January 1, 1990
Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on the methodology and rationale used to establish a payment rate for erythropoietin related to end stage renal disease. (Sec. 6219(c), Public Law 101-239; H.R. 3299.)	April 1, 1990
Comptroller General of the United States shall conduct a study and submit a report to the Committee on Ways and Means and the Senate Finance Committee on hospital-based and freestanding skilled nursing facilities. (Sec. 6026(a) and (b), Public Law 101-239; H.R. 3299.)	June 1, 1990

Topic	Due date
Secretary of Health and Human Services shall report to the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance of the advisability of continuing or terminating the exception under sec. 1886(h)(5)(F)(ii) of the Social Security Act for geriatric residencies and fellowships and of expanding such exception to cover other educational activities. Such study shall also examine the adequacy of the supply of faculty in the field of geriatrics. (Sec. 9202(c)(2), Public Law 99-272; H.R. 3128.)	July 1, 1990
Secretary of Health and Human Services shall submit a legislative proposal to Congress on eliminating separate average standardized amounts on various categories of hospitals. (Sec. 6003(i)(2)(A), Public Law 101-239; H.R. 3299.)	October 1, 1990
Secretary of Health and Human Services shall conduct a study and report to Congress on higher Medicare payment rates for sole community hospitals as a result of needed expansion of services at such hospitals. (Sec. 9111(c), Public Law 99-272; H.R. 3128.) (See Executive Communication 3995. Sept. 10, 1990. Letter from Secretary advising that this report will be included in report mandated by sec. 6003(i) of Public Law 101-239; H.R. 3299, due Oct. 1, 1990.)	October 1, 1990
Secretary of Health and Human Services shall conduct a study and submit a report to Congress on payment for portable x-ray services. (Sec. 6134, Public Law 101-239; H.R. 3299.)	December 19, 1990
Secretary of Health and Human Services shall conduct a study and submit a report to Congress on reimbursement for ambulance services. (Sec. 6136, Public Law 101-239; H.R. 3299.)	December 19, 1990
Secretary of Health and Human Services to conduct a study and report to Congress on end-stage renal disease program. (Sec. 4036(d)(3), Public Law 100-203.)	December 22, 1990
National Academy of Public Administration shall conduct a study and submit a report to Congress on Health Care Financing Administration personnel. (Sec. 6223(a) and (d), Public Law 101-239; H.R. 3299.)	December 31, 1990
Administrator of the Health Care Financing Administration shall submit a report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on research findings relating to prospective payments for hospital outpatient services. (Sec. 4151(2)(B)(i), Public Law 101-508; H.R. 5835.)	January 1, 1991
General Accounting Office shall conduct a study and submit a final report to Congress on Medicare capitation rates. (Sec. 4017(a), Public Law 100-203; H.R. 3545.)	January 1, 1991
Secretary of Health and Human Services shall conduct a standard and extended survey on home health agencies and report to Congress on the results of such evaluation. (Sec. 4022(a)(2)(A), Public Law 100-203; H.R. 3545.)	January 1, 1991
Secretary of Health and Human Services shall conduct a study and evaluation and report to Congress on amendments made to this section on the availability of covered items and shall evaluate the appropriateness of the volume adjustment for oxygen and oxygen equipment. (Sec. 4062(c)(1), Public Law 100-203; H.R. 3545.)	January 1, 1991
General Accounting Office shall conduct a study and report to Congress on the appropriateness of the level of payments allowed for covered items under the Medicare program. (Sec. 4062(c)(5), Public Law 100-203; H.R. 3545.)	January 1, 1991
Comptroller General of the United States shall conduct a study and submit a report to Congress on ownership by referring physicians of health care entities. (Sec. 6204(e), Public Law 101-239; H.R. 3299.)	February 1, 1991
Prospective Payment Assessment Commission and the Director of the Congressional Budget Office shall submit a report to Congress analyzing the legislative proposal submitted under Sec. 6003(i)(2)(A). (Sec. 6003(i)(2)(B), Public Law 101-239; H.R. 3299.)	February 1, 1991

Topic	Due date
Prospective Payment Assessment Commission shall conduct a study and submit a report to Congress on payment for services in hospital outpatient departments under sec. 6137(a)(4). (Sec. 6137(c), Public Law 101–239; H.R. 3299.)	March 1, 1991
Comptroller General of the United States shall conduct a study and submit a report to Congress on alternative payment methodology for malpractice components. (Sec. 6102(e)(1), Public Law 101–239; H.R. 3299.)	April 1, 1991
Comptroller General of the United States shall conduct a study and submit a report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on standards for use of and payment for items of durable medical equipment. (Sec. 6139, Public Law 101–239; H.R. 3299.)	April 1, 1991
Secretary of Health and Human Services shall conduct a study and submit a report to the Committee on Ways and Means and the Senate Finance Committee on methods used to compensate hospices for high-cost care. (Sec. 6016(a) and (b), Public Law 101–239; H.R. 3299.)	April 1, 1991
Secretary of Health and Human Services shall submit any research studies to be used in developing a proposal for a prospective payment system for skilled nursing facility services to the Committee on Ways and Means and the Senate Finance Committee. (Sec. 4008(k)(2)(A), Public Law 101–508; H.R. 5835.)	April 1, 1991
Physician Payment Review Commission shall conduct a study and submit a report to Congress on payments for assistants at surgery. (Sec. 6138, Public Law 101–239; H.R. 3299.)	April 1, 1991
Prospective Payment Assessment Commission shall report its recommendations on regarding passthrough payments for hemophilia inpatients. (Sec. 6011(c), Public Law 101–239; (H.R. 3299.)	May 21, 1991
Comptroller General of the United States shall conduct a study and submit a report to Congress on physician antitrust issues. (Sec. 6102(e)(9), Public Law 101–239; H.R. 3299.)	July 1, 1991
Secretary of Health and Human Services shall conduct a study and after consultation with the Physician Payment Review Commission, submit a report to Congress on the desirability of including time as a factor in establishing visit codes. (Sec. 6102(e)(4), Public Law 101–239; H.R. 3299.)	July 1, 1991
Physician Payment Review Commission shall conduct a study and submit a report to the Committees on Ways and Means and Energy and Commerce and Senate Finance Committee on payment for practice expenses. (Sec. 6102(e)(5), Public Law 101–230; H.R. 3299.)	July 1, 1991
Physician Payment Review Commission shall conduct a study and submit a report to Congress on geographic payment areas. (Sec. 6102(e)(6), Public Law 101–239; H.R. 3299.)	July 1, 1991
Physician Payment Review Commission shall conduct a study and submit a report to Congress on payment for nonphysician providers of Medicare services. (Sec. 6102(e)(7), Public Law 101–239; H.R. 3299.)	July 1, 1991
Physician Payment Review Commission shall conduct a study and submit a report to Congress on physician fees under Medicaid. (Sec. 6102(e)(8), Public Law 101–239; H.R. 3299.)	July 1, 1991
Secretary of Health and Human Services shall submit a proposal for a prospective payment system for skilled nursing facility services to the Committee on Ways and Means and the Senate Finance Committee. (Sec. 4008(k)(2)(B), Public Law 101–508; H.R. 5835.)	September 1, 1991
Secretary of Health and Human Services shall submit a proposal developed to replace the current prospective payment system for hospital outpatient services with a system under which such payments would be made on the basis of prospectively determined rates to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee. (Sec. 4151(2)(B)(ii), Public Law 101–508; H.R. 5835.)	September 1, 1991

Topic	Due date
Prospective Payment Assessment Commission shall submit a report to Congress on its study of Medicaid payments to hospitals. (Sec. 4002(g)(3), Public Law 101–508; H.R. 5835.)	October 1, 1991
Secretary of Health and Human Services shall submit a final report to the House Committees on Ways and Means and Energy and Commerce, and the Senate Committee on Finance on the progress made on a demonstration program designed to reduce disability and dependency through the provision of preventive health services to individuals entitled to benefits under title XVIII of the Social Security Act. (Sec. 9314(e)(1), Public Law 99–272; H.R. 3128.)	Oct. 30, 1991
Comptroller General shall submit a report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on its study of Medicare payments for prosthetic devices, orthotics, and prosthetics. (Sec. 4153(c)(2), Public Law 101–508; H.R. 5835.)	November 5, 1991
Secretary of Health and Human Services shall submit a report to Congress on a study of prohibition on hospital employment of physicians related to availability and accessibility of trauma and emergency care services. (Sec. 4008(c)(2), Public Law 101–508; H.R. 5835.)	November 5, 1991
Secretary of Health and Human Services to submit a final report to Congress on home health prospective payment demonstration project. (Sec. 4027(c), Public Law 100–203.)	December 22, 1991
Secretary of Health and Human Services shall conduct a study and report to Congress on the implementation of the resident assessment process for residents of skilled nursing facilities. (Sec. 4201(7)(c), Public Law 100–203; H.R. 3545.)	January 1, 1992
Comptroller General shall submit a preliminary report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on a study of the extension of secondary payor provisions for individuals with end stage renal disease. (Sec. 4203(c)(2)(B), Public Law 101–508; H.R. 5835.)	January 1, 1992
Secretary of Health and Human Services shall conduct a demonstration project and report to Congress on providing payment on a prepaid, capitated basis for community nursing and ambulatory care furnished to Medicare beneficiaries. (Sec. 4079(g), Public Law 100–203; H.R. 3545.)	January 1, 1992
Secretary of Health and Human Services shall submit a final report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on his study of chiropractic services related to health maintenance organizations. (Sec. 4204(f)(4), Public Law 101–508; H.R. 5835.)	January 1, 1992
Secretary of Health and Human Services shall submit a report to Congress on his plan to coordinate the physician review activities of peer review organizations and carriers. (Sec. 4205(c)(2), Public Law 101–508; H.R. 5835.)	January 1, 1992
Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal for a prospective payment system for skilled nursing facility services to the Committee on Ways and Means and the Senate Finance Committee. (Sec. 4008(k)(2)(C), Public Law 101–508; H.R. 5835.)	March 1, 1992
Prospective Payment Assessment Commission shall submit an analysis to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee with its comments on proposal of the Secretary of Health and Human Services relating to prospective payments for hospital outpatient services. (Sec. 4151(2)(B)(iii), Public Law 101–508; H.R. 5835.)	March 1, 1992
Secretary of Health and Human Services shall submit a report to Congress on a review of hospital regulations with respect to rural hospitals. (Sec. 4008(1)(2), Public Law 101–508; H.R. 5835.)	April 1, 1992

Topic	Due date
Secretary of Health and Human Services shall submit his proposal to the Committee on Ways and Means and the Senate Finance Committee on development of national prospective payment rates for current non-PPS hospitals. (Sec. 4005(b)(2)(A), Public Law 101-408; H.R. 5835.)	April 1, 1992
Secretary of Health and Human Services shall submit an interim report to the Committee on Ways and Means and the Senate Finance Committee on the progress of vocational rehabilitation demonstration projects. (Sec. 5120(d), Public Law 101-508; H.R. 5835.)	April 1, 1992
Comptroller General of the United States shall submit a report to Congress reviewing the proposal by the Secretary of Health and Human Services on requirements with respect to actuarial equivalence of adjusted average per capita cost related to health maintenance organizations. (Sec. 4204(b)(4), Public Law 101-508; H.R. 5835.)	May 1, 1992
Comptroller General of the United States shall submit a report to the Committees on Ways and Means and Energy and Commerce on his study of hospital staff privileges for physicians practicing in community health centers. (Sec. 4161(a)(7)(B), Public Law 101-508; H.R. 5835.)	May 5, 1992
Prospective Payment Assessment Commission shall submit an analysis of and comments on proposal under sec. 4005(b)(2)(A). (Sec. 4005(b)(2)(B), Public Law 101-508; H.R. 5835.)	June 1, 1992
Prospective Payment Assessment Commission shall submit a report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on a study of end state renal disease composite rates. (Sec. 4201(b)(2), Public Law 101-508; H.R. 5835.)	June 1, 1992
Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on a study of the effect of the release of Medicare prepayment medical review screen parameters on physician billings for the services to which the parameters apply. (Sec. 4111(c), Public Law 101-508; H.R. 5835.)	October 1, 1992
Secretary of Health and Human Services shall submit to Congress a preliminary report on the status of a 3-year demonstration project on staff-assisted home dialysis treatment. (Sec. 4202(e)(1), Public Law 101-508; H.R. 5835.)	December 1, 1992
Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on the results of a study of aggregation rule for claims for similar physicians' services. (Sec. 4113, Public Law 101-508; H.R. 5835.)	December 31, 1992
Secretary of Health and Human Services shall submit a report to Congress on the chronically mentally ill demonstration project. (Sec. 9412(a), Public Law 99-509; H.R. 5300.)	January 1, 1993
Secretary of Health and Human Services shall evaluate and submit a report to Congress on the implementation of the resident assessment process for residents of nursing facilities. (Sec. 4211(c), Public Law 100-203; H.R. 3545.)	January 1, 1993
Secretary of Health and Human Services shall submit a report to Congress on the progress made in implementing the nursing facility staffing requirements including the number and types of waivers approved and the number of facilities which have received waivers. (Sec. 4211(k), Public Law 101-203; H.R. 3545.)	January 1, 1993
Secretary of Health and Human Services shall conduct a demonstration project and report to Congress on payment for therapeutic shoes for individuals with severe diabetic foot disease. (See Public Law 101-203; H.R. 3545.)	April 1, 1993
Secretary of Health and Human Services shall submit a report to the Committee on Ways and Means and the Senate Finance Committee on a study of chiropractic services related to health maintenance organizations. (Sec. 4204(f)(4), Public Law 101-508; H.R. 5835.)	April 1, 1993

Topic	Due date
Secretary of Health and Human Services shall submit a report to the Committee on Ways and Means and the Senate Finance Committee on the research findings upon which he based a proposal developing a prospective payment system for home health services. (Sec. 4027(c)(2)(A), Public Law 101-508; H.R. 5835.)	April 1, 1993
Secretary of Health and Human Services shall submit a report to Congress on the extension of regional floor on standardized amounts related to prospective payment hospitals. (Sec. 4002(e), Public Law 101-508; H.R. 5835.)	June 1, 1993
Secretary of Health and Human Services shall submit a report to the Committee on Ways and Means and the Senate Finance Committee on a proposal developing a prospective payment system for home health services. (Sec. 4027(c)(2)(B), Public Law 101-508; H.R. 5835.)	September 1, 1993
Secretary of Health and Human Services shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, and other such factors as may be appropriate related to municipal health service demonstration projects. (Sec. 6134(2), Public Law 101-239; H.R. 3299.)	December 31, 1993
Secretary of Health and Human Services shall submit a report to Congress on the appropriateness of Medicare part B premium increases for residents of Puerto Rico and other U.S. commonwealths and territories. (Sec. 211(b), Public Law 101-360; H.R. 2470.)	1993
Propsective Payment Assessment Commission shall submit a report to the Committee on Ways and Means and the Senate Finance Committee on its analysis of the proposal of the Secretary of Health and Human Services developing a prospective payment system for home health services. (Sec. 4027(c)(2)(C), Public Law 101-508; H.R. 5835.)	March 1, 1994
Secretary of Health and Human Services shall submit a report to Congress on its study of the effects of coverage of injectable drugs for treatment of osteoporosis. (Sec. 4156(b)(2), Public Law 101-508; H.R. 5835.)	October 1, 1994
Comptroller General of the United States shall submit a final report on a study of the extension of secondary payer provisions for individuals with end stage renal disease. (Sec. 4203(c)(2)(B), Public Law 101-508; H.R. 5835.)	January 1, 1995
Secretary of Health and Human Services shall report to Congress on 5 demonstration programs on joint nursing graduate education and the characteristics of nurses trained under such programs. (Sec. 8411(a)(5), Public Law 100-647; H.R. 4333.)	January 1, 1995
Secretary of Health and Human Services shall conduct an evaluation of Medicare select policies amendments under this section and submit a report to Congress on such evaluation. (Sec. 4358(d), Public Law 101-508; H.R. 5835.)	January 1, 1995
Secretary of Health and Human Services shall submit a final report to the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance on the progress made on a demonstration program designed to reduce disability and dependency through the provision of preventive health services to individuals entitled to benefits under title XVIII of the Social Security Act. (Sec. 9314(e)(2), Public Law 99-272; H.R. 3128.) (Sec. 4164(a), Public Law 101-508; H.R. 5835.)	April 1, 1995
Secretary of Health and Human Services shall submit a final report to Congress evaluating the staff-assisted home dialysis demonstration project. (Sec. 4202(e)(2), Public Law 101-508; H.R. 5835.)	December 31, 1995
Secretary of Health and Human Services shall submit a report to Congress on the extension of waivers for social health maintenance organizations (HMOs). (Sec. 4018(b), Public Law 100-203; H.R. 3545.) (Sec. 4027(b)(4)(A)(II), Public Law 101-508; H.R. 5835.)	March 31, 1996

Topic	Due date
Secretary of Health and Human Services shall report on adjustments that may be required in Medicare prospective payment amounts for cases which have an unusually short length of stay or which are significantly less costly than the DRG payment with recommendations on how to address this issue. (H.Rept. 98–47 to accompany H.R. 1900; Public Law 98–21.)	No date certain
Secretary of Health and Human Services shall review the report of the Director of the Office of Technology Assessment, due to be submitted to Congress by Dec. 31, 1985, on Medicare part B payments to physicians. (Sec. 2309(c), Public Law 98–369; H.R. 4170.)	No date certain
Secretary of Health and Human Services shall study and report to Congress on the extent to which the Medicare economic index (MEI) appropriately and equitably reflects the changes in the provision of the physicians' services to Medicare beneficiaries. (Sec. 9331(c)(4), Public Law 99–509; H.R. 5300.)	No date certain
Secretary of Health and Human Services shall study and report to Congress on the advisability of redefining the localities designated by carriers for payment purposes. (Sec. 9331(e)(1), Public Law 99–509; H.R. 5300.)	No date certain

APPENDIX B. HEALTH STATUS, INSURANCE, AND EXPENDITURES OF THE ELDERLY, AND BACKGROUND DATA ON LONG-TERM CARE

Although the health status of the elderly appears to have been improving in recent decades, many elderly persons have conditions that require medical and long-term health care, sometimes in substantial amounts. Nearly all elderly persons have some insurance that protects them, at least partially, from the expenses arising from health care use. Many are well insured for their acute care needs—that is, for hospital and physician services. Others face greater risk of high out-of-pocket expenditures. This appendix reports on the health status, health insurance, and health care expenditures of the elderly.

HEALTH STATUS

By various measures, the health status of the elderly population has been improving over the years. For example, life expectancy at age 65 has increased from 13.9 years in 1950 to 16.8 years in 1984 (see table 1). The improvements in life expectancy—or, alternatively, the declines in mortality rates—have been greater for females than for males. Morbidity indicators—such as the incidence of high blood pressure—also improved among those aged 65 to 74 years between the early 1960's and the late 1970's (see table 2).

TABLE 1.—LIFE EXPECTANCY AT BIRTH AND AT 65 YEARS OF AGE, BY SEX, BY RACE, UNITED STATES, SELECTED YEARS 1900–88

[Remaining life expectancy in years]

Year	At birth			At 65 years			At birth	
	Both sexes	Male	Female	Both sexes	Male	Female	White	Black
1900 [1] [2]	47.3	46.3	48.3	11.9	11.5	12.2	47.6	[3] 33.0
1950 [2]	68.2	65.6	71.1	13.9	12.8	15.0	69.1	60.7
1960 [2]	69.7	66.6	73.1	14.3	12.8	15.8	70.6	63.2
1970	70.9	67.1	74.8	15.2	13.1	17.0	71.7	64.1
1980	73.7	70.0	77.4	16.4	14.1	18.3	74.4	68.1
1984	74.7	71.2	78.2	16.8	14.6	18.6	75.3	69.7
1985	74.7	71.2	78.2	16.7	14.6	18.6	75.3	69.5
1986	74.8	71.3	78.3	16.8	14.7	18.6	75.4	69.4
1987	75.0	71.5	78.4	16.9	14.8	18.7	75.6	69.4
Provisional data:								
1987 [2]	74.9	71.5	78.3	16.9	14.8	18.6	75.5	69.7
1988 [2]	74.9	71.4	73.3	16.9	14.8	18.6	75.5	69.5
1989 [2]	75.2	71.8	78.5	17.2	15.2	18.8	75.9	69.7

[1] Death registration area only; includes 10 States and the District of Columbia.

[2] Includes deaths of nonresidents of the United States.

[3] Figure is for the all other population.

Source: National Center for Health Statistics, Health, United States, 1989, Hyattsville, Maryland: Public Health Service, 1990.

TABLE 2.—SELECTED HEALTH STATUS INDICATORS FOR PERSONS 65–74 YEARS OF AGE, BY SEX, 1960–62, 1971–74, AND 1976–80

[Percent of population]

Health status indicator	Both sexes			Male			Female		
	1960–62	1971–74	1976–80	1960–62	1971–74	1976–80	1960–62	1971–74	1976–80
Borderline or definite elevated blood pressure [1]	73.8	70.3	63.1	65.9	65.4	62.0	80.3	74.1	63.9
Definite elevated blood pressure [2]	48.7	40.9	34.5	40.5	36.4	33.3	55.4	44.4	35.5
High-risk serum cholesterol levels [3]	37.3	31.3	27.2	20.8	19.9	18.1	50.8	40.0	34.3
Overweight [4]	34.6	31.5	32.7	23.8	23.0	25.2	43.3	38.0	38.5

[1] Borderline or definite elevated blood pressure is defined as either systolic pressure of at least 140 mmHg or diastolic pressure of at least 90 mmHg or both based on a single measurement.

[2] Definite elevated blood pressure is defined as either systolic pressure of at least 160 mmHg or diastolic pressure of at least 95 mmHg or both based on a single measurement.

[3] High-risk serum cholesterol levels are defined by age-specific cut points of the cholesterol distribution. For 40 years of age and over, high risk is greater than 260 milligrams/deciliter. Risk levels defined by NIH Consensus Development conference statement on lowering blood cholesterol, December 10, 1984.

[4] Overweight is defined for men as body mass index greater than or equal to 27.8 kilograms/meter^2, and for women as body mass index greater than or equal to 27.3 milograms/meter^2. These cut points were used because they represent the sex-specific 85th percentiles for persons 20–29 years of age in the 1976–80 National Health and Nutrition Examination Survey.

Source: National Center for Health Statistics, Health, United States, 1985, DHHS Pub. No. (PHS) 86–1232, pp. 76–79. Data are based on physical examinations of a sample of the civilian, noninstitutionalized population.

Despite the trend toward improved health status of the elderly, their needs for medical and long-term care services remain substantial. First, greater life expectancy postpones the probable need for terminal illness care. (About two-thirds of the deaths in the United States are of the elderly. A recent study found that the 6 percent of Medicare beneficiaries who died in 1978 accounted for 28 percent of Medicare expenditures.[1]) Second, many of the elderly have one or more chronic conditions, many of which give rise to the need for continuing health care. Table 3 shows the incidence of several common chronic conditions among the elderly. Nearly half report having arthritis, about 40 percent report high blood pressure, and almost 30 percent report heart disease. The incidence of many chronic conditions is directly related to age and inversely related to family income.

Self-assessed health is a common method used to measure health status, with responses ranging from "excellent" to "poor." Over one-third of the elderly report their health to be excellent or very good, but nearly another third report fair or poor health (see table 4). Lower-income elderly are more likely to report fair or poor health—40 percent of those with incomes under $10,000, compared to under 30 percent at incomes above this level.

TABLE 3.—SELECTED CHRONIC CONDITIONS PER 1,000 ELDERLY PERSONS, BY AGE AND FAMILY INCOME, 1988

Chronic Condition	All elderly	Age		Family income			
		65–74	75 and over	Less than $10,000	$10,000 to $19,999	$20,000 to $34,999	$35,000 and over
Arthritis	486	445	550	608	452	471	397
Cataracts	168	118	246	183	174	131	150
Hearing impairment	315	274	381	308	364	259	314
Deformity or orthopedic impairment	161	151	177	182	179	136	140
Hernia of abdominal cavity	58	54	64	72	67	46	51
Diabetes	92	95	88	98	101	76	71
Heart disease	296	272	334	346	324	269	257
High blood pressure	373	373	374	472	396	345	321
Emphysema	38	36	41	52	48	34	([1])

[1] Sample size is too small for reliable estimate.

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, Vital and Health Statistics: Current estimates from the National Health Interview Survey, 1988, Series 10, No. 173, October 1989.

---

[1] J. Lubitz and R. Prihoda, "The Use and Costs of Medicare Services in the Last Two Years of Life," Health Care Financing Review, Volume 5, 1984, pp. 117-131.

TABLE 4.—SELF-ASSESSED HEALTH STATUS OF THE ELDERLY, BY FAMILY INCOME, 1988

[In percent]

Characteristic	All persons [1] (thousands)	All health status [3]	Self-assessed health status [2]				
			Excellent	Very good	Good	Fair	Poor
All elderly [4]	28,683	100.0	16.3	21.5	32.8	19.9	9.5
Family income:							
Under $10,000	6,157	100.0	11.7	17.2	31.1	25.0	15.0
$10,000 to $19,999	7,682	100.0	15.5	21.7	32.5	21.3	9.0
$20,000 to $34,999	5,193	100.0	18.2	23.5	34.9	17.0	6.4
$35,000 and over	3,476	100.0	25.1	25.8	30.9	11.9	6.3

[1] The categories related to this concept result from asking the respondent, "Would you say—health is excellent, very good, good, fair, or poor?" As such, it is based on the respondent's opinion and not directly on any clinical evidence.

[2] Includes unknown health status.

[3] Excludes unknown health status.

[4] Includes unknown health status.

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, Vital and Health Statistics: Current Estimates from the National Health Interview Survey, 1988 Series 10, No. 173 October 1989.

CAUSES OF DEATH FOR THE ELDERLY [2]

In the United States, three out of four elderly persons die from heart disease, cancer, or stroke. Heart disease was the major cause of death in 1950, and remains so today even though there have been rapid declines in death rates from heart disease since 1968, especially among females. Death rates from cancer continue to rise in comparison to heart disease, especially deaths caused by lung cancer (chart 1). In 1985, however, heart disease accounted for 43 percent of all deaths among persons 75–84, while cancer accounted for 20 percent of all deaths in this age group.[3] Even if cancer were eliminated as a cause of death, the average life span would be extended by less than 2 years because of the prevalence of heart disease. Eliminating deaths due to heart disease, on the other hand, would add an average of 5 years to life expectancy at age 65, and would lead to a sharp increase in the proportion of older persons in the total population.[4]

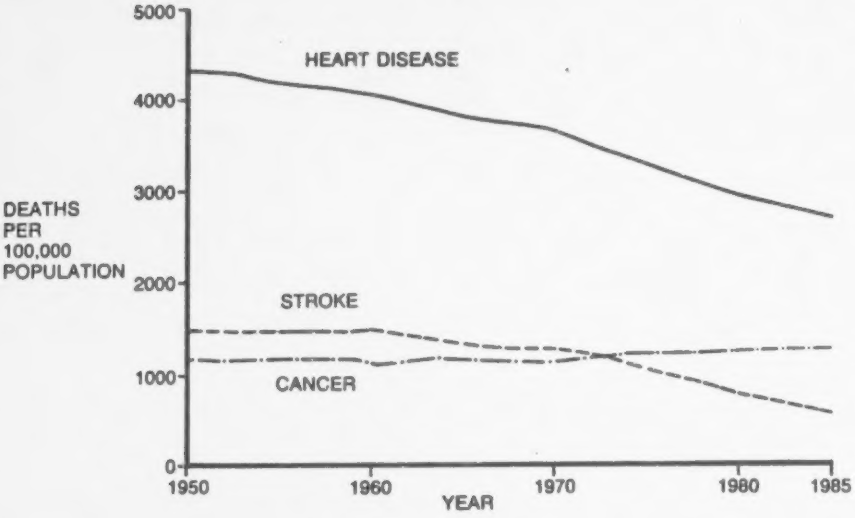
---

[2] This entire section is from Aging America: Trends and Projections, 1987–88 edition.

[3] National Center for Health Statistics. "Annual Summary of Births, Marriages, Divorces, and Deaths: United States, 1985." Monthly Vital Statistics Report Vol. 34, No. 13 (September 1986).

[4] National Center for Health Statistics. "United States Life Tables Eliminating Certain Causes of Death." U.S. Decennial Life Tables for 1979–1981 Vol. 1, No. 2 (forthcoming).

CHART 1. DEATH RATES FOR LEADING CAUSES OF DEATH FOR PEOPLE AGE 75–84: 1950–85



SOURCE: National Center for Health Statistics. *Health, United States, 1986*. DHHS Pub. No. (PHS)87-1232, Washington: Department of Health and Human Services, December 1986.

National Center for Health Statistics. "Annual Summary of Births, Marriages, Divorces, and Deaths: United States, 1985." *Monthly Vital Statistics Report* Vol. 34, No. 13 (September 1986).

The third leading cause of death among the elderly—stroke (cerebrovascular disease)—has been decreasing over the past 30 years. Reasons for this dramatic decline are not fully understood. Part of the decline may be attributable to better control of hypertension. Better diagnosis and improved management and rehabilitation of stroke victims may also be related factors.[5] In 1985, cerebrovascular disease accounted for only 9 percent of all deaths in the 75 to 84 age group.

Table 5 shows the 10 leading causes of death for three subgroups of the older population.

The factors which have led to reductions in mortality may or may not also lead to overall improvements in health status. If Americans continue to live only to about age 85, control of life-threatening disease could produce a healthier older population. But, if the life-span is increased dramatically in future years beyond age 85, the onset of illness may only be delayed, without an actual shortening of the period of illness.

---

[5] National Center for Health Statistics. Health, United States, 1985. DHHS Pub. No. (PHS) 86-1232, Washington: Department of Health and Human Services, December 1985.

TABLE 5.—DEATH RATES FOR TEN LEADING CAUSES OF DEATH AMONG OLDER PEOPLE, BY AGE: 1984

[Rates per 100,000 population in age group]

Cause of death	65+	65–74	75–84	85+
All causes	5,102	2,848	6,399	15,224
Diseases of the heart	2,186	1,103	2,749	7,251
Malignant neoplasms	1,042	835	1,272	1,604
Cerebrovascular diseases	476	177	626	1,884
Chronic obstructive pulmonary diseases	199	141	270	331
Pneumonia and influenza	182	54	216	883
Diabetes	95	59	126	217
Accidents	87	50	107	257
Atherosclerosis	83	17	88	488
Nephritis, nephrotic syndrome, nephrosis	58	27	76	201
Septicemia	41	20	52	142
All other causes	654	365	816	1,965

Source: National Center for Health Statistics. "Advance Report of Final Mortality Statistics, 1984." Monthly Vital Statistics Report Vol. 35, No. 6, Supplement (2) (September 1986).

MEDICARE REIMBURSEMENT AND OUT-OF-POCKET LIABILITIES OF THE ELDERLY

Tables 6 through 8 illustrate for 4 selected years how Medicare reimbursement, acute health care costs, and out-of-pocket liabilities of Medicare enrollees have changed. The years chosen are 1975, 1980, 1985, and 1990 (projected values). Constant 1990 dollar values were obtained using the implicit price deflator for GNP.

The fastest-growing component of Medicare reimbursement is for benefits under the Supplementary Medical Insurance (SMI) program. For SMI, reimbursements increase at an annual rate of 14.0 percent, while the growth in total costs (including enrollees' share of costs) is 12.9 percent (see table 6). As a result, the share of SMI costs reimbursed by Medicare increases significantly over the period—from about 64 percent in 1975 to over 73 percent by 1990. Through 1985, the growth in Medicare's share is due to the declining significance of the SMI deductible, so that more enrollees' costs were eligible for reimbursement.

In the Hospital Insurance (HI) program, by contrast, the rate of growth in reimbursement is slower than the growth in enrollee's copayment costs. Consequently, the share of HI costs reimbursed by Medicare has decreased from 94 percent in 1975 to 91 percent in 1990.

Overall, the share of costs reimbursed by Medicare has remained constant. The percentage of costs paid by Medicare for services covered under Medicare was 82.6 percent in 1975 and 83.1 percent in 1990 (see table 6). The other side of this—the share of costs paid directly by enrollees—is shown in the third panel of table 7. Total direct costs plus Medicare reimbursement equals the total or 100 percent. This analysis differs from that published last year in that

the 1990 analysis includes only services covered by Medicare while the 1989 analysis includes outpatient drug expenditures.

TABLE 6.—REIMBURSEMENTS AND OUT-OF-POCKET COSTS UNDER MEDICARE, SELECTED CALENDAR YEARS

[Incurred costs per HI or SMI enrollee]

	1975	1980	1985	1990	Annual growth 1975–90 (percent)
	In current dollars				
Hospital insurance:					
Reimbursement	$458	$906	$1,540	$1,921	10.0
Copayments	30	65	118	183	12.8
Total	488	971	1,658	2,104	10.2
Supplementary medical insurance:					
Reimbursement	183	401	769	1,309	14.0
Copayments	82	138	236	364	10.4
Balance-billing	22	56	87	112	11.4
Total	287	595	1,091	1,785	12.9
Total Medicare reimbursement	641	1,307	2,309	3,230	11.4
Total costs under Medicare	776	1,566	2,750	3,890	11.3
	In constant 1990 dollars				
Hospital insurance:					
Reimbursement	1,015	1,389	1,825	1,921	4.3
Copayments	67	99	140	183	7.0
Total	1,082	1,488	1,965	2,104	4.5
Supplementary medical insurance:					
Reimbursement	405	615	911	1,309	8.1
Copayments	183	212	279	364	4.7
Balance-billing	49	86	103	112	5.7
Total	637	913	1,293	1,785	7.1
Total Medicare reimbursement	1,421	2,004	2,735	3,230	5.6
Total costs under Medicare	1,719	2,401	3,258	3,890	5.6
Percent of costs paid by Medicare	82.6	83.5	84.0	83.1	0.3

Note.—1990 values are projected. The implicit price deflator for gross national product was used to obtain constant dollars.

Source: Congressional Budget Office (February 1990 baseline).

TABLE 7.—ENROLLEE COSTS UNDER MEDICARE, SELECTED CALENDAR YEARS

[Incurred costs per HI or SMI enrollee]

	1975	1980	1985	1990	Annual growth 1975–90 (percent)
	In current dollars				
HI copayments	$30	$65	$118	$183	12.8
SMI copayments	82	138	236	364	10.4
Balance-billing	22	56	87	112	11.4
Total direct costs	135	259	441	659	11.2
Premium costs	80	110	186	343	10.2
Total enrollee costs	215	369	627	1,002	10.8
Enrollee per capita income [1]	5,158	8,357	12,485	17,484	8.5
	In constant 1990 dollars				
HI copayments	67	99	140	183	7.0
SMI copayments	183	212	279	364	4.7
Balance-billing	49	86	103	112	5.7
Total direct costs	298	397	522	659	5.4
Premium costs	178	169	220	343	4.5
Total enrollee costs	476	566	743	1,002	5.1
Enrollee per capita income [1]	11,429	12,813	14,793	17,484	2.9
	Percent of costs under Medicare paid by enrollees, by source of payment				
HI copayments	3.9	4.1	4.3	4.7	
SMI copayments	10.6	8.8	8.6	9.4	
Balance-billing	2.8	3.6	3.2	2.9	
Total direct costs	17.4	16.5	16.0	16.9	
Premium costs	10.4	7.1	6.8	8.8	
Total	27.7	23.6	22.8	25.8	
Enrollee-paid costs as a percent of enrollee per capita income [1]	4.2	4.4	5.0	5.7	

[1] From Current Population Survey, adjusted for underreporting.

Note.—1990 values are projected. The implicit price deflator for gross national product was used to obtain constant dollars.

Source: Congressional Budget Office (February 1990 baseline).

In constant dollars, HI copayments have increased the most rapidly between 1975 and 1995. Premium costs have risen at the slowest rate. However, over the last 5 years, premium costs have risen the most rapidly and are the primary reason real enrollee costs have risen. In contrast, the cost to the enrollee from balance-billing has hardly risen at all over the last 5 years—a direct policy result of the participating physician program. See table 8 for deductible amounts and monthly premium amounts under Medicare.

Enrollees are spending an increasing share of their income for health care. In 1975, about 4.2 percent of enrollees' per capita income went to cover their share of acute health care costs under Medicare. By 1990, enrollees will have to pay an estimated 5.7 percent of their per capita income to cover their share of costs under Medicare.

Total health spending as a percent of after-tax income increased substantially between 1972 and 1988 for the elderly. In 1972, among aged households out-of-pocket health spending represented 7.8 of after-tax income. By 1988, out-of-pocket health spending had increased to 12.5 percent of after-tax income.

TABLE 8.—COPAYMENT AND PREMIUM VALUES UNDER MEDICARE, SELECTED CALENDAR YEARS

	1975	1980	1985	1990	Annual growth 1975–90 (in percent)
	In current dollars				
Hospital insurance:					
Hospital deductible	$92	$180	$400	$592	13.2
Supplementary medical insurance:					
Annual deductible	60	60	75	75	1.5
Monthly premium [1]	6.70	9.20	15.50	28.60	10.2
	In constant 1990 dollars				
Hospital insurance:					
Hospital deductible	204	276	474	592	7.4
Supplementary medical insurance:					
Annual deductible	133	92	89	75	−3.7
Monthly premium [1]	14.85	14.11	18.37	28.60	4.5

[1] The 1980 SMI monthly premium amount is the average of values for the first and second halves of the year.

Source: Congressional Budget Office (February 1990 baseline).

ANALYZING TRENDS IN MEDICARE SPENDING, 1967–1996 [1]

Between 1980 and 1985, total Medicare spending for hospital inpatient services grew at an annual rate of 14.6 percent. The estimated growth rate for 1985 to 1991 is 5.5 percent. The difference in these rates is due to changes in four separate trends: Medicare enrollment, admissions per enrollee, real expenditures per admission, and the general rate of inflation.

Reduced inflation contributes to the lower rate of growth in total Medicare inpatient spending. General inflation is estimated at 3.6

---

[1] The following section borrows heavily from a memorandum prepared by Sandra Christensen, of the Congressional Budget Office, February 4, 1991.

percent per year from 1985 to 1991, compared with 5.6 percent for 1980 to 1985. The growth rate for 1985 to 1991 would thus be about 2 percentage points higher at the previous rate of inflation.

Real Medicare inpatient spending per enrollee removes the effects of changes in Medicare enrollment and general inflation from total Medicare inpatient spending (see table 9). Since both enrollment and prices are almost always increasing the growth of real per enrollee spending is slower than the growth of total spending. Real inpatient spending per enrollee grew at an annual rate of 6.6 percent between 1980 and 1985, and the estimate for 1985 to 1991 is 0.2 percent. The difference in these rates is due to changes in admissions per enrollee and real expenditures per admission.

The number of Medicare enrollees grew at an annual rate of 1.7 percent between 1980 and 1985, and the estimate for 1985 to 1991 is the same. Medicare enrollment thus makes no contribution to the observed difference in spending growth between the early and late 1980's.

The trend in admissions per enrollee did change, however. In 1984, Medicare's peer review organizations were set up to monitor inpatient cases for appropriateness of treatment and site of care. Simultaneously, admission rates among the Medicare population—which had been increasing through 1983—began to decline. Although admission rates inched up again after 1987, rates in 1989 for people age 65 or more (a proxy for the Medicare population) were still only 85 percent of rates in 1983. Perhaps Medicare's preadmission approval requirements for certain procedures, coupled with retrospective payment denials for care deemed inappropriate, encouraged physicians either to forgo some elective procedures for their Medicare patients or to move them to the outpatient sector. It should be noted that admissions for the non-Medicare population has decreased for each year since 1981. Given this trend, the credit for lower admissions rates must go to changes in practice patterns and other factors not associated with Medicare policy.

A reduction in real expenditures per admission makes the greatest contribution to decreased spending growth. This decline is primarily due to smaller increases in payment rates under PPS since the very large increases in the first 2 years (1984 and 1985). At the previous rate of increase in Medicare expenditures per admission, the estimated growth in total inpatient spending between 1985 and 1991 would be 12.0 percent per year, rather than 5.5 percent. The estimated real growth in spending per enrollee would have been 6.4 percent per year, rather than 0.2 percent.

Costs in hospital outpatient departments have dropped relative to the previous trend, indicating that hospital inpatient costs have not simply been shifted to the outpatient sector. Savings relative to trend for hospital outpatient and home health services may in large part reflect unsustainably large rates of growth during the trend period from 1975 through 1980. Introduction of a new payment methodology (a blend of a fixed rate and the hospital's costs) for certain surgical procedures performed in outpatient departments tended to reduce costs somewhat, but this effect was partially offset by the shift of services from the inpatient sector. During the 1980s, Medicare's administrative agents implemented stricter standards for determining coverage of home health services (tending to reduce costs), but increased demand for services from patients discharged earlier from hospitals than they would have been prior to the prospective payment system would have worked to increase Medicare's spending for home health.

Growth in spending for physicians' services has not slowed as much as hospital spending relative to previous trends despite the disproportionate impact on physicians of budget reconciliation bills. Apparently, growth in the volume of physicians' services has accelerated by enough to offset some of the enacted reductions in payment rates. Although not all of this growth was in response to fee cuts, growth in the volume of services was enough to completely offset the fee freeze in place from 1984 through 1986, but was insufficient to offset entirely the effects of subsequent fee cuts for "overvalued" procedures.

Spending for skilled nursing facilities (SNFs) increased significantly. During the period from 1975 through 1980, real spending per enrollee for SNFs was falling. This trend was reversed during the 1980s. In 1988, growth in SNF spending accelerated sharply because of a revision in the manual used by administrative agents to determine Medicare coverage that greatly relaxed the definition of covered care to make it conform with legislative language. Growth in SNF spending further accelerated in 1989 under provisions of the Medicare Catastrophic Coverage Act, which briefly eliminated the requirement for a hospital stay prior to a covered SNF stay and which reduced the copayments required of enrollees for SNF stays.

Table 9 illustrates Medicare spending per enrollee in constant 1990 dollars where the implicit price deflator for the gross national product has been used to obtain constant dollars. The first column includes both Medicare benefits and administration. All other columns include spending on benefits only.

From 1975 to 1985, total real spending per enrollee grew at an annual rate of 7.4 percent. From 1985 to 1991, there was a dramatic decline in the real growth rate in hospital expenditures per capita; exclusively in the inpatient hospital growth rate. The growth rate fell from 6.6 percent to 0.2 percent between the first 5 years of the 1980's and the 6 subsequent years. While the outpatient growth rate increased slightly, the total real hospital spending growth rate declined from 6.7 percent annually to 1.1 percent between 1980 to 1985 as compared with 1985 to 1991. This decline in the hospital spending growth rate results in a 4.2 percentage point reduction in the total Medicare spending growth rate—a decline of 58 percent.

If the total growth rate in Medicare spending continued between 1985 and 1991 at the same 7.3 percent rate exhibited between 1980 and 1985, total Medicare costs per enrollee would be $4,227 in 1991, or almost $900 per enrollee more than the actual estimate. This would imply additional Medicare spending of $30 billion in that year.

TABLE 9.—REAL SPENDING PER ENROLLEE [1]

[Fiscal years, in constant 1990 dollars]

Fiscal years	Medicare	HI	SMI	Hospital inpatient	SNF	Home health and hospice	Hospital outpatient	Physician and lab	Total hospital
Estimates by the Health Care Financing Administration									
1967	648	469	135	447	18	5	2	132	449
1968	960	661	259	592	61	12	6	248	598
1969	1,104	770	284	701	61	13	12	267	713
1970	1,114	740	317	685	46	14	15	296	700
1971	1,143	781	303	744	31	14	18	278	761
1972	1,194	818	313	789	23	13	23	284	811
1973	1,100	764	285	737	21	11	21	259	758
1974	1,182	805	306	775	22	14	34	266	809
1975	1,355	941	353	904	25	19	50	296	954
1976	1,481	1,014	397	970	25	26	63	326	1,034
1977	1,637	1,123	455	1,074	26	31	77	369	1,151
1978	1,744	1,195	483	1,146	24	34	87	387	1,233
1979	1,811	1,226	522	1,176	22	37	95	418	1,271
1980	1,954	1,318	575	1,266	21	40	105	460	1,371
1981	2,117	1,430	625	1,373	21	45	114	501	1,487
1982	2,300	1,556	686	1,482	21	53	135	550	1,617
1983	2,449	1,628	763	1,542	22	66	146	616	1,688
1984	2,554	1,684	806	1,588	22	76	146	659	1,734
1985	2,775	1,848	859	1,744	22	84	154	703	1,898
1986	2,817	1,806	946	1,703	21	84	185	760	1,888
1987	2,886	1,752	1,073	1,648	22	84	207	864	1,855
1988	2,960	1,739	1,154	1,636	24	81	221	931	1,857
1989	3,071	1,808	1,194	1,655	69	86	237	955	1,892
1990	3,326	1,977	1,280	1,793	77	110	258	1,020	2,050
Projections by the Congressional Budget Office									
1991	3,334	1,950	1,311	1,766	69	117	261	1,047	2,027
1992	3,519	2,045	1,399	1,852	70	125	287	1,109	2,139
1993	3,690	2,114	1,501	1,914	72	131	321	1,177	2,235
1994	3,915	2,222	1,618	2,013	75	138	360	1,254	2,373
1995	4,155	2,334	1,744	2,117	77	145	402	1,338	2,519
1996	4,420	2,457	1,885	2,233	78	151	448	1,432	2,681
Average annual growth rates (in percent)									
1975–80	7.6	7.0	10.3	7.0	−2.9	16.3	16.1	9.2	7.5
1980–85	7.3	7.0	8.3	6.6	.5	15.9	8.0	8.9	6.7
1985–91	3.1	0.9	7.3	0.2	20.9	5.6	9.2	6.9	1.1
1991–96	5.8	4.7	7.5	4.8	2.6	5.1	11.4	6.5	5.8
1975–85	7.4	7.0	9.3	6.8	−1.2	16.1	12.0	9.0	7.1
1985–95	4.1	2.4	7.3	2.0	13.3	5.6	10.1	6.6	2.9

---

[1] The first column includes both Medicare benefits and administration. All other columns include benefits only. Total hospital is the sum of hospital inpatient and outpatient spending.

Source: Congressional Budget Office (February 1991). Implicit price deflator for gross national product used to obtain constant dollars.

TOTAL HEALTH CARE EXPENDITURES FOR THE ELDERLY

Expenditures for personal health care services for the elderly nearly quadrupled between 1977 and 1987, rising from $43 billion to an estimated $162 billion (see table 10).

Government programs (Federal and State) account for two-thirds of estimated 1987 spending for the aged (see table 16). The most significant of these programs is Medicare which pays for nearly half of the aged's health bill. Medicaid funds about 12 percent of the expenditures.

Health insurance coverage of the elderly

Table 11 shows the sources of health insurance coverage for the noninstitutionalized population aged 65 and over in 1988. Over 95 percent of the aged population was enrolled in Medicare, and more than three-quarters of the Medicare enrollees had some form of supplemental coverage. Beneficiaries with incomes below the Federal poverty level were least likely to have supplemental coverage; those who had such coverage were more likely to rely on Medicaid. Higher income groups were more likely to obtain supplemental coverage through individually purchased medigap policies or through employer-based plans. Of those with incomes greater than 200 percent of the poverty level, 41 percent had employer coverage, compared to just 5 percent of those below poverty. (It should be noted that the Current Population Survey (CPS), on which table 11 is based, does not distinguish between primary and secondary sources of coverage. Some of the individuals reporting both Medicare and employer-based plans relied on the employer plan as their primary insurer, with Medicare functioning as a secondary payer.) About 4 percent of the elderly had more than one source of supplemental coverage, such as both employer and individual medigap coverage, or both medigap and Medicaid. This figure does not include individuals who obtained multiple policies from a single basic coverage source, such as those who purchased more than one private medigap policy. The number of such indivduals cannot be determined from the CPS; however, according to an American Association of Retired Persons (AARP) 1989 survey, 24 percent of respondents in the national sample owning insurance in addition to Medicare, own two or more policies.

About 1.3 million elderly persons did not report Medicare coverage in 1988. Of these, 1 million had coverage from some other source. An estimated 30 percent of these are Federal annuitants who are covered through the Federal Employees Health Benefits Program (FEHBP; this estimate is based on unpublished data from the Office of Personnel Management). Approximately 300,000 persons aged 65 or over were without health insurance coverage in 1988.

TABLE 10.—PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE, 1977, 1984, AND 1987

[In millions of dollars]

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1977					
Total	43,425	18,906	7,782	10,696	6,041
Private	15,669	2,319	3,323	5,424	4,603
Consumer	15,499	2,263	3,320	5,352	4,564
Out-of-pocket	12,706	927	2,147	5,264	4,368
Insurance	2,793	1,336	1,173	88	195
Other private	170	56	3	72	39
Government	27,756	16,587	4,458	5,272	1,438
Medicare	19,171	14,087	4,158	348	578
Medicaid	6,049	733	232	4,453	631
Other government	2,536	1,767	68	470	230
1984					
Total	119,872	54,200	24,770	25,105	15,798
Private	39,341	6,160	9,827	13,038	10,316
Consumer	38,875	5,964	9,818	12,856	10,237
Out-of-pocket	30,198	1,694	6,468	12,569	9,467
Insurance	8,677	4,270	3,350	287	770
Other private	466	196	9	182	79
Government	80,531	48,040	14,943	12,067	5,482
Medicare	58,519	40,524	14,314	539	3,142
Medicaid	15,288	2,595	467	10,418	1,808
Other government	6,724	4,920	162	1,110	532
1987					
Total	162,000	67,900	33,500	32,800	27,800
Private	60,600	10,100	11,900	19,200	19,500
Government	101,500	57,900	21,600	13,600	8,300
Medicare	72,200	47,300	20,300	600	4,100
Medicaid	19,500	3,300	500	11,900	3,700

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review, Fall 1984 No. 1, p. 1; and Waldo, Daniel R. et al. "Health Expenditures by Age Group, 1977 and 1987." Health Care Financing Review, Summer 1989, Vol. 10, No. 4 and errata reprint Fall 1989, Vol. 11, No. 1, p. 167.

TABLE 11.—SOURCES OF HEALTH INSURANCE COVERAGE FOR THE NON-INSTITUTIONALIZED ELDERLY, BY RATIO OF INCOME TO POVERTY, 1988

[Population in thousands]

	Individuals with family income—							
	Under 100 percent of poverty		100–200 percent of poverty		Over 200 percent of poverty		Total [1]	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Medicare	4,460	94.2	8,599	98.1	14,660	94.4	27,719	95.5
Medicare only	1,710	36.1	2,710	30.9	2,105	13.5	6,526	22.4
Medicare plus:								
Private supplement	1,114	23.5	3,624	41.2	5,123	33.0	9,861	33.9
Employer coverage	231	4.9	1,314	15.0	6,421	41.4	7,966	27.5
Medicaid	1,240	26.2	557	6.4	100	.6	1,898	6.6
CHAMPUS	(2)	(3)	130	1.5	236	1.5	397	1.4
2 or more supplements	135	2.9	264	3.1	675	4.4	1,075	3.7
Insured through non-Medicare plan	111	2.3	113	1.3	799	5.2	1,023	3.5
Uninsured	160	3.4	(2)	(3)	(2)	(3)	275	1.0
Total [1]	4,734	100.0	8,767	100.0	15,521	100.0	29,022	100.0
Percent of all elderly		16.3		30.2		53.5		100.0

[1] Items may not sum to total due to rounding.

[2] Less than 75,000.

[3] Less than 1 percent.

Source: Congressional Research Service analysis of data from the March 1989 Current Population Survey.

BACKGROUND DATA ON LONG-TERM CARE

The phrase "long-term care" refers to a broad range of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. Chronic illnesses or conditions often result in both functional impairment and physical dependence on others for an extended period of time. Major subgroups of persons needing long-term care include the elderly and non-elderly disabled, persons with developmental disabilities (primarily persons with mental retardation), and persons with mental illness. This section of appendix B focuses on the elderly long-term care population. A concluding section discusses the long-term care needs of chronically ill children.

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute medical illnesses, which occur suddenly and may be resolved in a relatively short period of time, chronic conditions last for an extended period of time and are not typically curable. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These conditions may include heart disease, strokes, arthritis, osteoporosis, and vision and hearing impairments. Dementia, the chronic, often progressive loss of intellectual function, is also a major cause of disability in the elderly.

The presence of a chronic illness or condition alone does not necessarily result in a need for long-term care. For many individuals, their illness or condition does not result in a functional impairment or dependence and they are able to go about their daily routines without needing assistance. It is when the illness or condition results in a functional or activity limitation that long-term care services may be required.

The need for long-term care by the elderly is often measured by assessing limitations in a person's capacity to manage certain functions or activities. For example, a chronic condition may result in dependence in certain functions that are basic and essential for self-care, such as bathing, dressing, eating, toileting, and/or moving from one place to another. These are referred to as limitations in "activities of daily living," or ADLs. Another set of limitations, which reflect lower levels of disability, are used to describe difficulties in performing household chores and social tasks. These are referred to as limitations in "instrumental activities of daily living," or IADLs, and include such functions as meal preparation, cleaning, grocery shopping, managing money, and taking medicine. Limitations can vary in severity and prevalence, so that persons can have limitations in any number of ADLs or IADLs, or both.

Long-term care services are often differentiated by the settings in which they are provided. In general, services are provided either in nursing homes or in home and community-based care settings. Nursing home care includes a wide variety of services that range from skilled nursing and therapy services to assistance with such personal care functions as bathing, dressing, and eating. Nursing home services also include room and board services. All of these services are considered to be formally provided services, in that they require persons to pay the facility for care that is provided.

Home and community-based care also includes a broad range of skilled and personal care services, as well as a variety of home management activities, such as chore services, meal preparation, and shopping. Home care services can be provided formally by home care agencies, visiting nurse associations, and day care centers. Home care is also provided informally by family and friends who are not paid for the services they provide. In contrast to nursing home care, which by necessity is formally provided care, most home and community-based care is provided informally by family and friends. Research has shown that more than 70 percent of those elderly persons living in the community and needing long-term care assistance rely exclusively on nonpaid sources of assistance for their care.

The long-term care population

Chart 2 shows that an estimated 10.6 million persons of all ages require assistance with one or more ADLs or IADLs. About two-thirds of this total, or 7.1 million persons, are elderly. This is about one-quarter of the nation's elderly population.

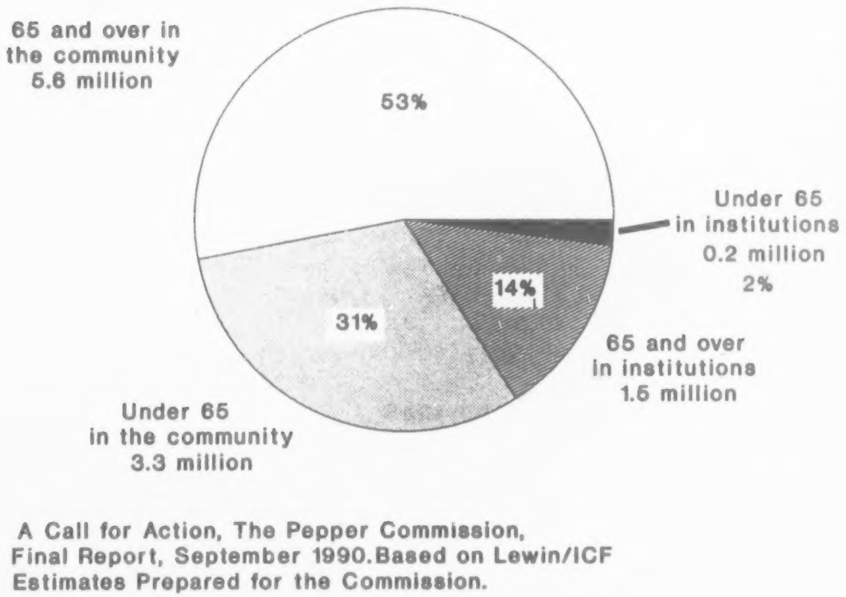
Another 3.5 million persons under the age of 65 are limited in ADLs and/or IADLs. Some of these persons have congenital or developmental conditions such as cerebral palsy or mental retardation. Others are disabled from traumatic accidents or the onset of chronic conditions such as multiple sclerosis.[6] It should be noted that these estimates do not adequately measure the need for long-term care among young children, since ADL and IADL limitations are not appropriate measures of their disabilities. Chronically ill children will be discussed at the end of this chapter.

Chart 2 also indicates that the great majority of persons with ADL and/or IADL limitations live in the community. Of the total disabled population, 84 percent live in the community. The nursing home population amounts to only 16 percent of the total, with the elderly by far the greatest share of this group.

Based on the projected growth of the elderly population in the future, major increases can be anticipated in the number of persons needing assistance with ADL and/or IADL limitations. Currently 32 million persons are 65 years of age and older. That number is expected to double to about 66 million by the year 2030. The 85+ population, the group at greatest risk of needing and using long-term care services, is expected to increase from 3.3 million persons in 1990 to 8.1 million in 2030.[7] One study has estimated that the number of elderly needing assistance with ADLs and/or IADLs will grow from 7.1 million to 13.8 million by 2030, and the number requiring nursing home care will grow from 1.5 million to 5.3 million by that year.[8]

CHART 2. PERSONS WITH ADL AND/OR IADL LIMITATIONS, 1990

Total: 10.6 million



Source: A Call for Action, The Pepper Commission, Final Report, September 1990. Based on Lewin/ICF Estimates Prepared for the Commission.

---

[6] A Call for Action, p. 91.

[7] U.S. Senate, Special Committee on Aging. "Aging America: Trends and Projections." November 1989. Sen. Prt. 101-59, p. 4.

[8] A Call for Action, p. 108.

The nursing home population [9]

Demographic characteristics

Analysis of the 1985 National Nursing Home Survey (NNHS) shows that the great majority of nursing home residents are 65 years of age and older. In 1985, 88 percent of residents were 65 years of age and older, and 12 percent were under the age of 65. As the top half of table 12 indicates, less than 5 percent of the total elderly population in the country were residents of nursing homes on any given day in 1985, and 0.1 percent of the under 65 population were residents in that year.

Although in the aggregate less than 5 percent of the total elderly population was in a nursing home on any given day in 1985, younger and older age groups of the elderly show very different rates of utilization. Table 12 and chart 3 show that about 1 percent of the 65–74 age group and about 6 percent of the 75–84 age group resided in nursing homes in 1985. For the very old, those 85 and older, however, the incidence rate increases dramatically. In 1985, 22 percent of the 85 and older group resided in nursing homes. This group accounted for 40 percent of total nursing home residents, and 45 percent of the elderly nursing home population.

Chart 3 also illustrates that, among each of the age groups of the elderly, women were more likely to reside in nursing homes than men. For the elderly as a whole, women were twice as likely to be residing in nursing homes in 1985 as men (6 percent of women as opposed to 3 percent for men). The difference for men and women is particularly striking in the 75–84 and 85 and older age groups. Higher incidence rates for women, largely the result of longer life expectancies for women, mean a nursing home population that is predominately female. Chart 4 indicates that 72 percent of nursing home residents were female in 1985.

TABLE 12.—NURSING HOME RESIDENTS AS A PROPORTION OF TOTAL POPULATION, BY AGE AND SEX, 1985

[All nursing home and U.S. population estimates in thousands]

Age	All residents		
	Nursing home pop.	U.S. pop.	Percent
Under 65	173	210,197	0.1
65 to 74	212	17,009	1.2
75 to 84	508	8,836	5.7
85 and older	597	2,695	22.1
65 and older	1,317	28,540	4.6
Total	1,490	238,737	0.6

---

[9] This material is drawn largely from "Characteristics of Nursing Home Residents and Proposals for Reforming Coverage of Nursing Home Care," by Richard Price, Richard Rimkunas, and Carol O'Shaughnessy, CRS Report for Congress, No. 90-471 EPW, September 24, 1990.

TABLE 12.—NURSING HOME RESIDENTS AS A PROPORTION OF TOTAL POPULATION, BY AGE AND SEX, 1985 — Continued

[All nursing home and U.S. population estimates in thousands]

Age	Males			Females		
	Nursing home pop.	U.S. pop.	Percent	Nursing home pop.	U.S. pop.	Percent
Under 65	89	104,623	0.1	84	105,574	0.1
65 to 74	81	7,475	1.1	132	9,534	1.4
75 to 84	141	3,293	4.3	367	5,543	6.6
85 and older	112	769	14.6	485	1,926	25.2
65 and older	334	11,537	2.9	984	17,003	5.8
Total	423	116,160	0.4	1,068	122,577	0.9

Note.—Figures are based on the number of current nursing home residents and U.S. Census Bureau estimates of the resident population. Figures do not reflect the likelihood of any individual being in a nursing home; rather these estimates indicate the percent of the total population that resided in nursing homes at a given point in time in 1985.

Source: Estimates prepared by CRS using the 1985 National Nursing Home Survey, Current Resident File, and U.S. Bureau of the Census, Current Population Report, United States Population Estimates, by Age, Sex and Race: 1980 to 1987, series P–25, No. 1022, March 1988. These estimates are subject to limitations of the data and methods employed.

CHART 3. SHARE OF RESIDENT POPULATION IN NURSING HOMES, 1985

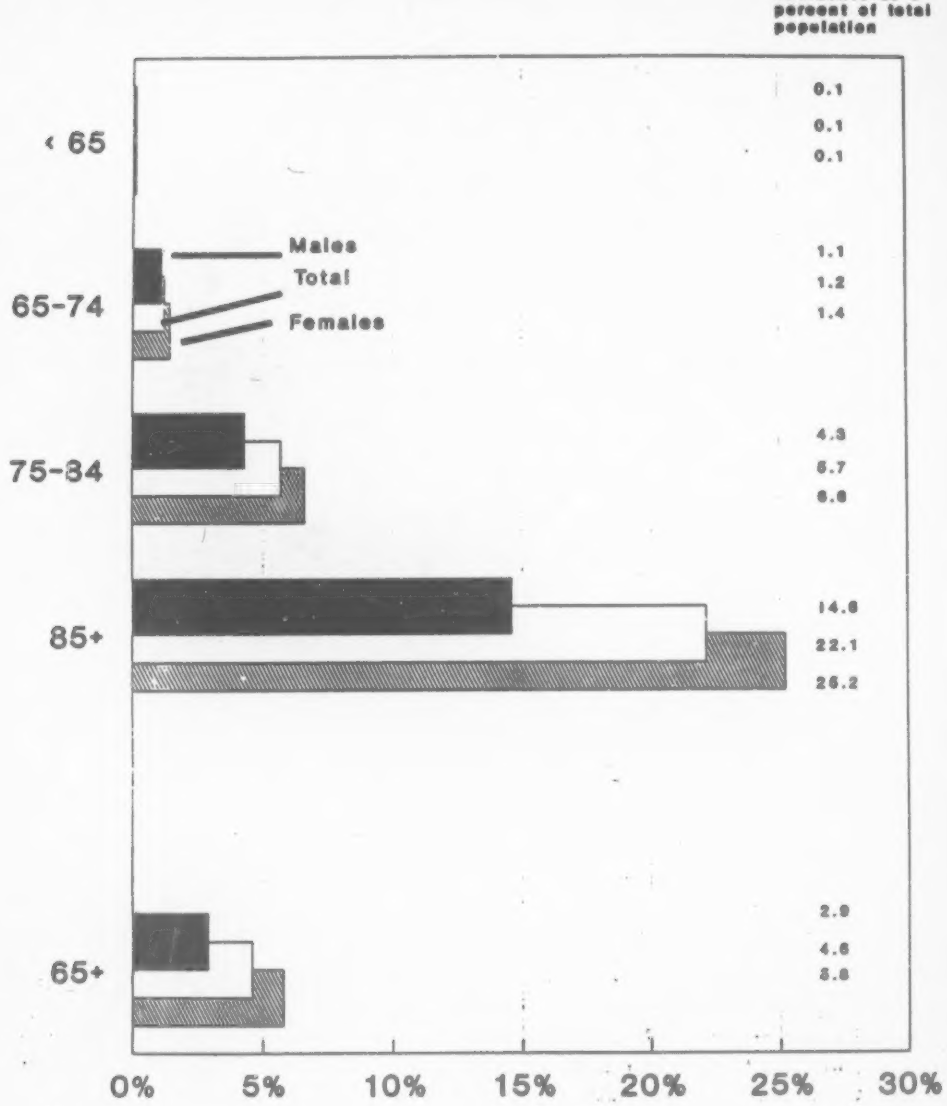
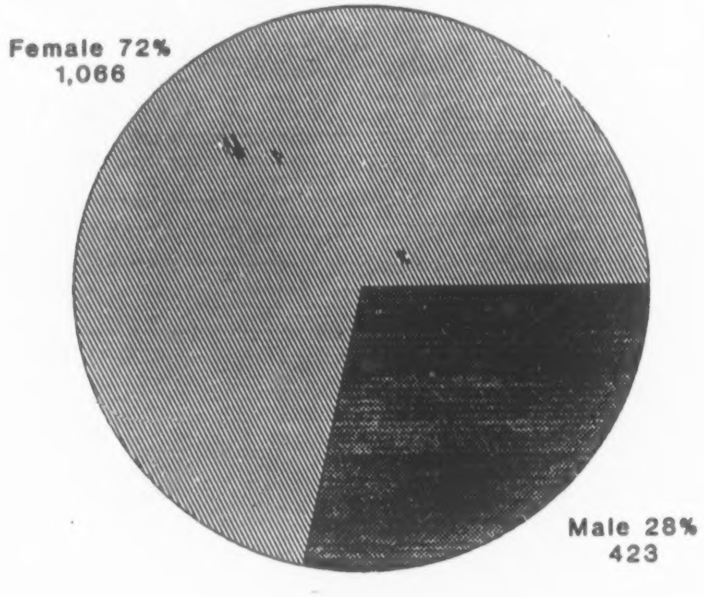


CHART 4. DISTRIBUTION OF CURRENT RESIDENTS, BY SEX, 1985

[In Thousands]



Total Residents = 1.5 million

Studies have shown that persons without spouses are more likely to enter nursing homes than persons with spouses.[10] Because many disabled persons often require a great deal of assistance, spouses are often the only person outside of nursing homes able to provide such intensive care. Chart 5 indicates that, at admission, only 16 percent of nursing home residents were married. Of the remaining, 56 percent were widowed, 18 percent had never been married, and about 8 percent were either divorced or separated.

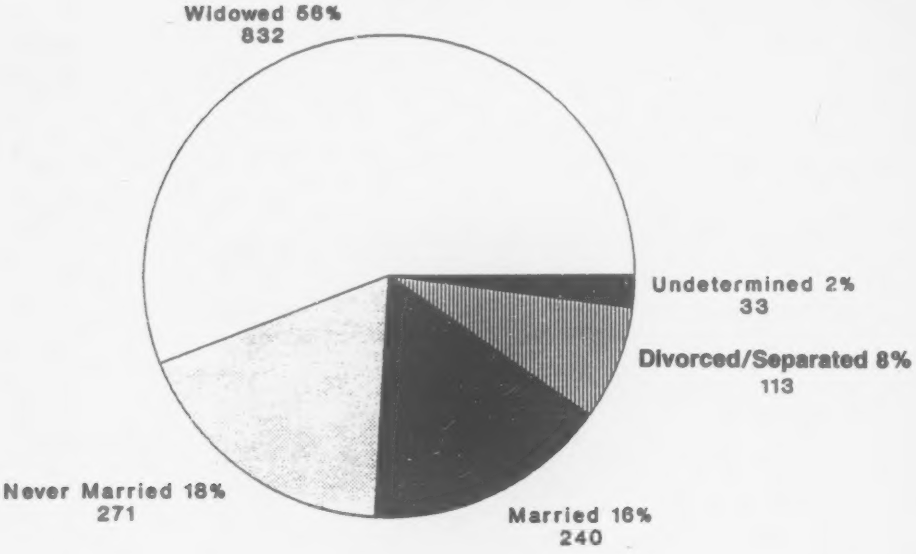
Chart 6 shows that, among the elderly, the proportion of residents who were married at admission decreases with age, and the proportion who were widowed increases.

---

[10] "Financing of Long-Term Care." Submitted to the Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services. Contract No. HHS-100-86-051, September 30, 1988. p. I-9.

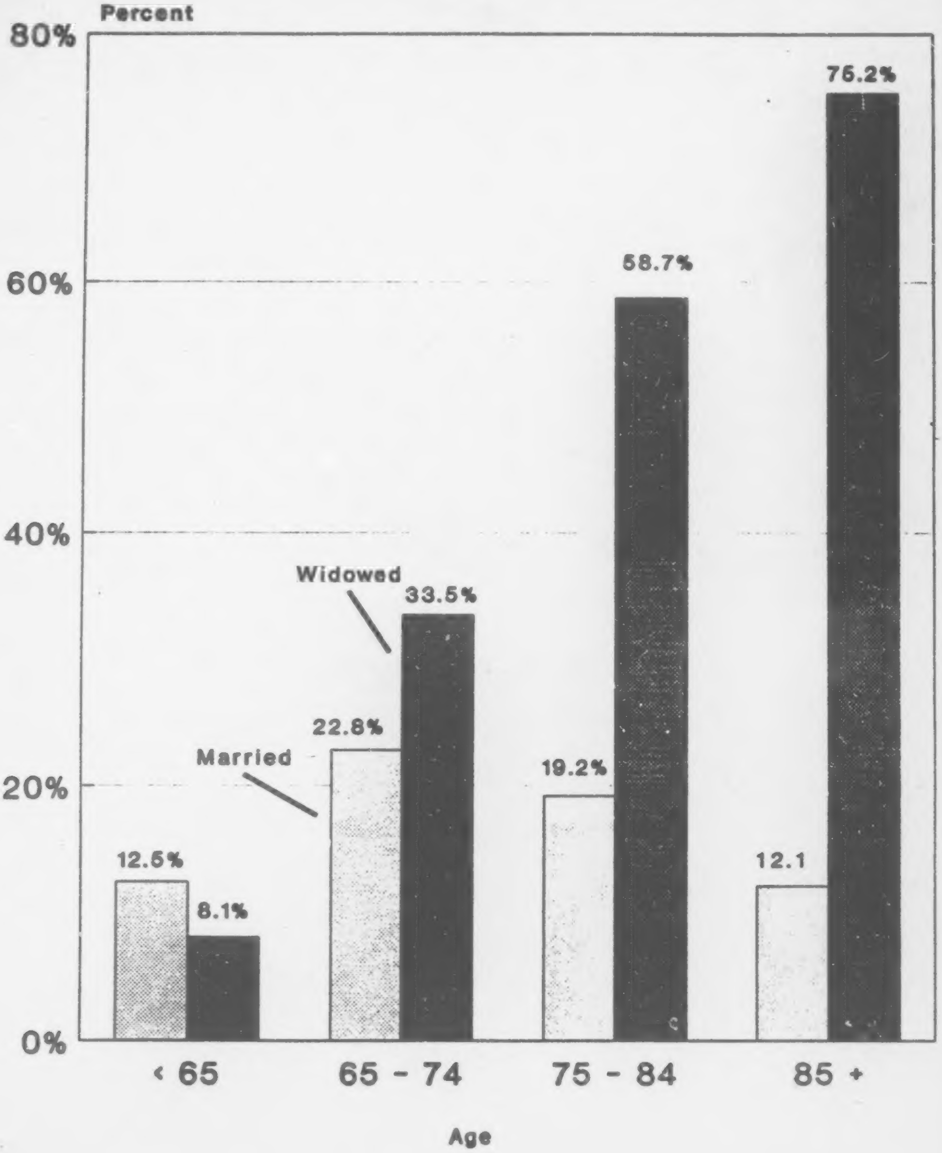
CHART 5. DISTRIBUTION OF CURRENT RESIDENTS, BY MARITAL STATUS AT ADMISSION, 1985

In Thousands



Total Residents = 1.5 million

CHART 6. PERCENT OF CURRENT RESIDENTS, MARRIED AND WIDOWED, BY AGE, 1985

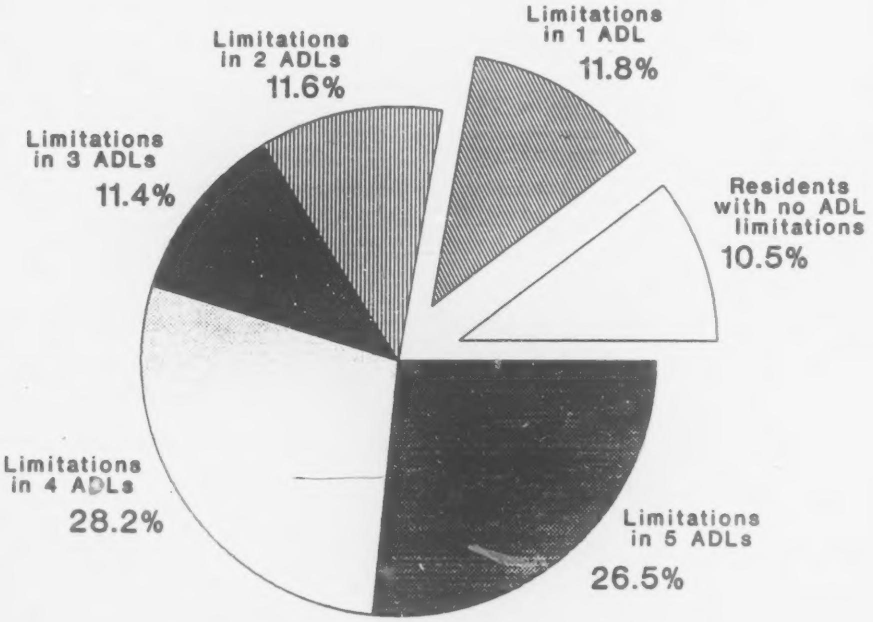


Number and Type of ADL Limitations of Nursing Home Residents

Chart 7 presents data on the number of limitations in ADLs exhibited by nursing home residents of all ages in 1985. This figure shows that nursing home residents have substantial functional limitations. Seventy-eight percent of residents needed the assistance of others in two or more ADLs. Almost 55 percent of the nursing home population was severely impaired with four or more ADLs.

Chart 7 also shows that slightly more than 20 percent of nursing home residents were judged to have no, or only one, activity limitation. A review of the diagnosis classifications of residents by their number of ADLs shows that residents whose primary diagnosis was a mental disorder were disproportionately represented among the total number of residents who had no activity limitation. About 35 percent of those with no ADLs had a mental disorder as their primary diagnosis. Mental disorders include a wide range of disabilities, including dementias, psychoses, and mental retardation. Persons with mental disorders but without limitations in ADLs may be residents of nursing homes because they require supervision or because of the unavailability of other housing and social service arrangements in the community.

CHART 7. DISTRIBUTION OF CURRENT RESIDENTS BY NUMBER OF ADL LIMITATIONS, 1985



Total Residents = 1.5 million

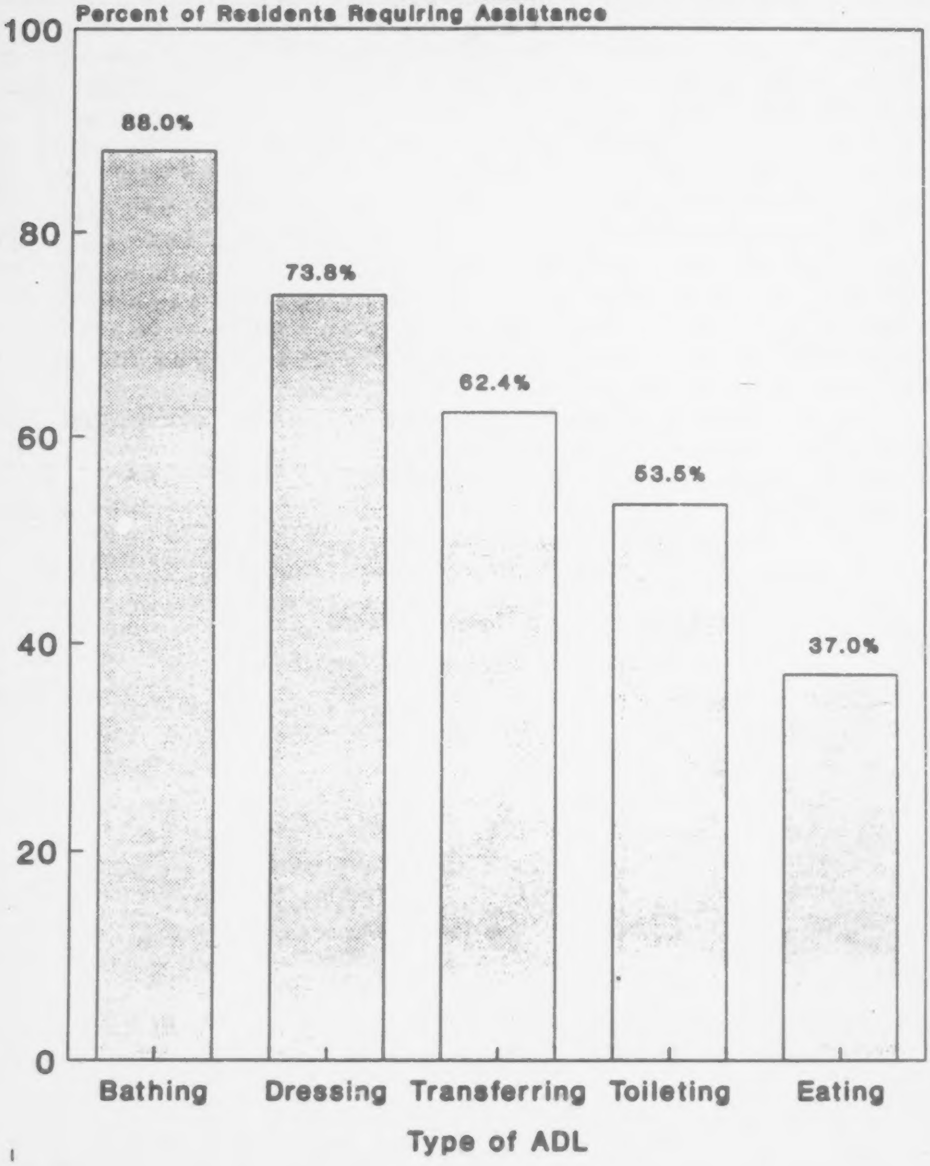
Chart 8 presents data on the extent to which nursing home residents have various kinds of limitations in ADLs. The most frequently found limitation among residents was bathing, with 88 percent of residents needing the assistance of another person. The least prevalent ADL was in eating, with slightly more than one-third of residents needing assistance with this ADL. About three-quarters of residents needed assistance to dress and two-thirds needed assistance in getting out of a bed or chair (transferring). About half of all residents needed the assistance of others in getting to the toilet or in caring for an ostomy bag or catheter.

In developing measures of functional limitations, researchers have found an ordered regression in functional abilities as part of the natural aging process. Loss of functioning begins with activities which are most complex and least basic, such as bathing or dressing. Functions which are least complex and most basic, such as feeding oneself, are retained longer. That is, persons are most able to retain their ability to feed themselves, but are less likely to retain their ability to bathe or dress without the assistance of others.[11] In addition, persons who are the most severely impaired are least likely to be able to eat independently, and therefore are more likely to have limitations in all the other ADLs. This ordered regression in stages of functioning is reflected in the nursing home population. As shown in chart 8, higher proportions of residents needed assistance in bathing or dressing than those who needed assistance in eating.

---

[11] Katz, Sidney and Amechi Akpom. "A Measure of Primary Sociobiological Functions." International Journal of Health Services, Vol. 6, No. 3, 1976.

CHART 8. PERCENT OF RESIDENTS REQUIRING ASSISTANCE OF ANOTHER PERSON IN PERFORMING ACTIVITY, 1985



Nursing home length of stay

The profile of nursing home residents presented above suggests a fairly homogeneous population: largely very elderly, female, widowed, and very disabled. However, an examination of length-of-stay patterns among the nursing home population suggests a more diverse group of persons using care than might be suggested by demographic data alone.

Analysis of discharge data from the NNHS shows at least two major users of nursing home care, as illustrated in charts 9 and 10. Chart 9 portrays the distribution of persons discharged from nursing homes in 1984-85, according to their length of stay. Chart 10 shows the distribution of days of care used by all discharged residents. It should be noted that the discharge file of the NNHS does not provide a comprehensive picture of the use of nursing home care by a single group of persons over time. As a result, estimates based on discharge survey data must be considered very general orders of magnitude of lengths of stay in a nursing home.

Chart 9 shows that most nursing home stays are relatively short. About 52 percent of persons discharged from nursing homes had stays of less than 90 days and about 63 percent of persons discharged had stays of less than 6 months. In contrast, 27 percent of persons discharged had long stays of 1 year or longer, and 17 percent had stays of 2 years or longer.

The distribution of total days of care used by discharged residents is strikingly different. Chart 10 shows that persons with stays of less than 3 months accounted for only 4 percent of days of care. Those with stays of less than 6 months accounted for 8 percent of all days. On the other hand, persons with stays of 2 or more years accounted for about 73 percent of all discharge days. In other words, persons with short stays accounted for the majority of persons discharged from nursing homes, but very few of the days of care used. Those with long stays accounted for relatively few of those persons discharged from nursing homes, but the bulk of days used.

CHART 9. DISTRIBUTION OF DISCHARGED RESIDENTS BY LENGTH OF STAY, 1984–85

Length of stay

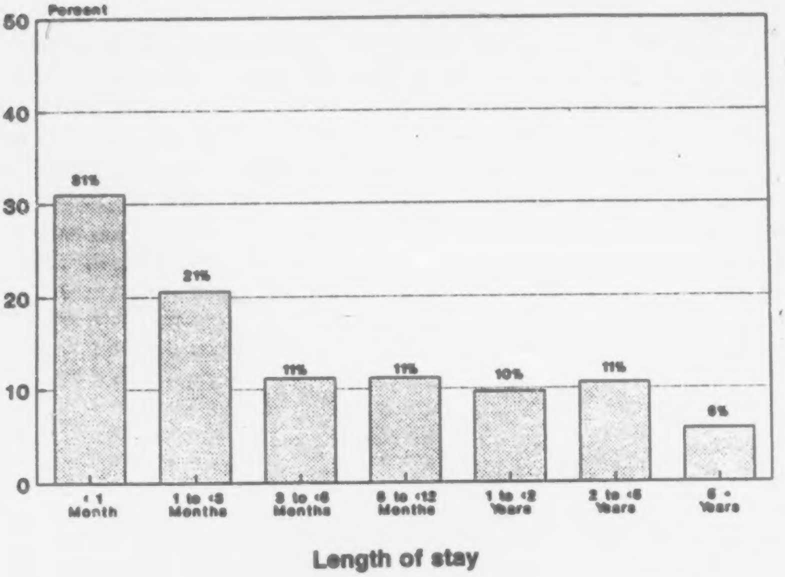
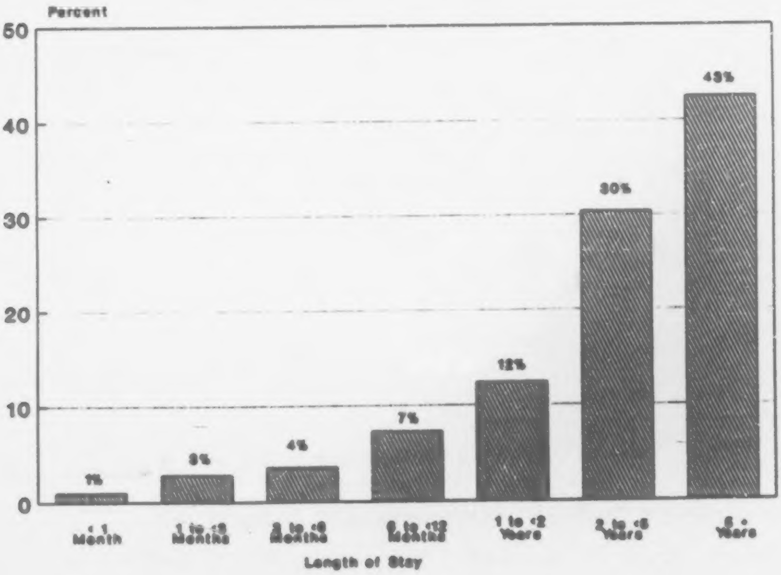


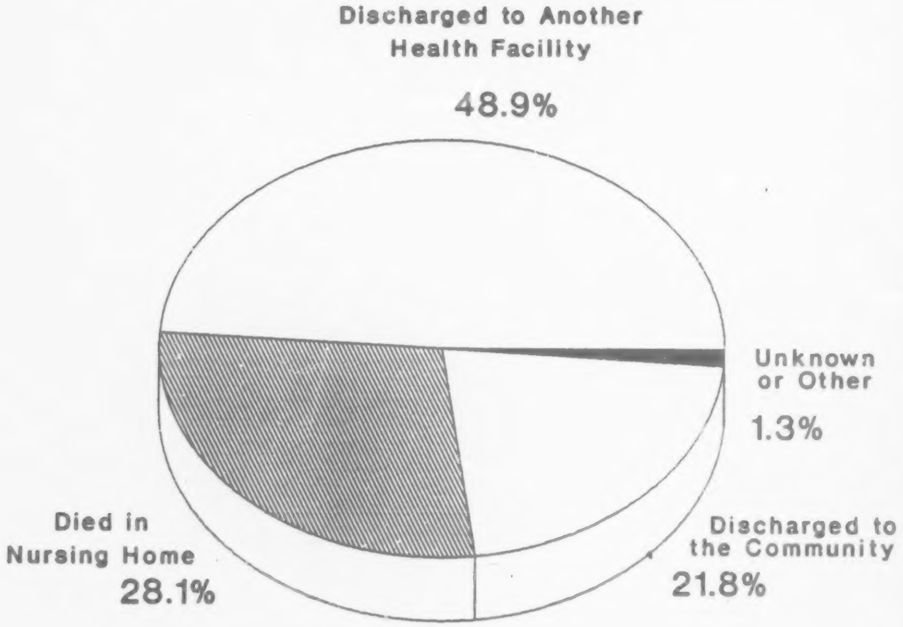
CHART 10. DISTRIBUTION OF TOTAL DAYS USED BY DISCHARGED RESIDENTS, BY LENGTH OF STAY. 1984–85



Status of nursing home residents following discharge

Chart 11 shows the distribution of residents by their status following discharge. In 1984-85, the largest share of persons—about 50 percent—were discharged from the nursing home to a hospital or other health care facility, including nursing homes (about 7 percent were discharged to another long-term care facility). About 28 percent of discharges were due to death in the nursing home. About 22 percent of the residents were discharged to the community. This mortality rate and the rate of return to the community may be conservative estimates. For example, 10 percent of those discharged from nursing homes to other health facilities died in these other facilities. Others are likely to have returned to the community.

CHART 11. DISTRIBUTION OF DISCHARGED RESIDENTS BY LIVING ARRANGEMENT AFTER DISCHARGE, 1984–85



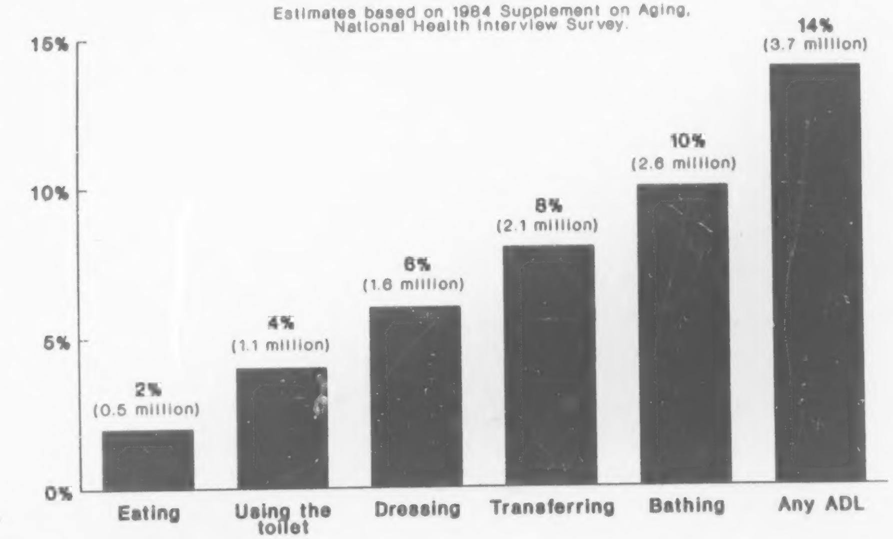
Total Residents • 1.2 Million

The community-based long-term care population

Chart 2 above showed that the great majority of persons with ADL and/or IADL limitations live in the community. Almost 9 million persons of all ages, or 84 percent of the total population with ADL and/or IADL limitations, live in the community. The elderly represented almost 63 percent of this total.

Chart 12 shows the number and percent of elderly persons living in the community with ADL limitations by type of limitation, as of 1984.[12] A total of 3.7 million elderly persons living in the community, or 14 percent of the total elderly population, reported some limitation in their ability to bathe, transfer, dress, toilet, or eat. The prevalence of these ADLs forms a hierarchy similar to that shown above in chart 8 for the nursing home population. The most prevalent limitation was in bathing, with 10 percent of the elderly reporting difficulty with this ADL. The least common was in eating, with 2 percent of elderly persons reporting difficulty.

CHART 12. PERCENT OF ELDERLY IN THE COMMUNITY WITH ADL LIMITATIONS, BY TYPE OF LIMITATION, 1984


Estimates based on 1984 Supplement on Aging, National Health Interview Survey.

Source: Rowland, Diane. Health Affairs, v.8, p.42. Measuring the Elderly's Need for Home Care.

% based on 26.4 million persons 65 years or older.

Chart 13 indicates that 54 percent of the elderly population with any kind of ADL limitation in 1984 had two or more ADLs. This was about 2 million persons. Almost 22 percent has 4 or 5 limitations. The severity of impairment is not uniform in the disabled population. Among the 2 million persons with two or more ADLs, 1.1 million reported some difficulty and 0.9 million reported a lot of difficulty or inability to perform at least two ADLs.[13]

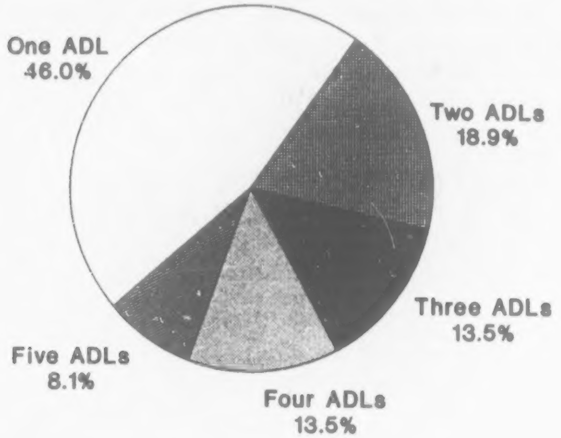
---

[12] Rowland, Diane. "Measuring the Elderly's Need for Home Care," Health Affairs, winter 1989, vol. 8, p. 42.

[13] Rowland, p. 43.

CHART 13. DISTRIBUTION OF ADL'S AMONG NONINSTITUTIONALIZED ELDERLY POPULATION HAVING ONE OR MORE ADL LIMITATIONS, 1984

Estimates based on 1984 Supplement on Aging, National Health Interview Survey.



Source: Rowland, Diane. Health Affairs, v.8, p.43. Measuring the Elderly's Need for Home Care.

Total=3.7 million impaired persons 65 years or older.

Studies have shown that the great bulk of care provided to persons living in the community with ADL and/or IADL limitations is provided informally by family and friends who are not paid for the care they provide. Chart 14 indicates that 70 percent of severely disabled elderly persons receiving long-term care in the community relied solely on informally provided care. Only 3 percent relied only on formal or paid care.

More than 7 million spouses, adult children, other relatives, friends, and neighbors provided unpaid assistance to disabled elderly persons in 1984.[14] Seven out of ten informal caregivers bear the major responsibility for care provided, and one of three is a sole provider. Three-quarters of all caregivers are female—wives and daughters of persons needing care. Research has shown that caregivers often reduce their work hours, take time off without pay, or quit jobs because of elder caregiving responsibilities. In addition, many caregivers are themselves elderly—one-quarter are between the ages of 65 to 74 and another 10 percent are 75 or older.

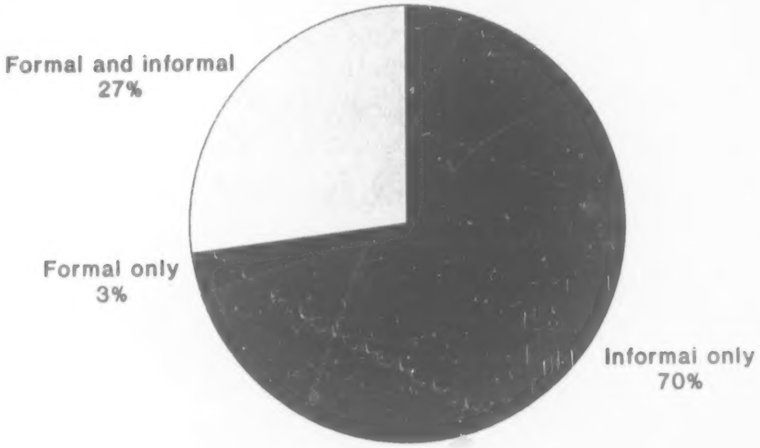
Use of formal, paid services by elderly persons living in the community is related to various characteristics of this group.[15] Differences in functional status have been found to be strongly related to use of formal home and community-based care, with the likelihood of using any formal service increasing as levels of impairment increase. Age is also linked to the use of formal services, largely explained by the fact that age is associated with decreasing functional status. In general and in each age group of the elderly, more women use formal home and community-based care services than men. This is related to the longer life expectancies of women. Persons living alone are more than twice as likely to use formal services as compared to those living with other persons. In addition, the amount of money spent on home care services has been found to be directly related to income; that is, out-of-pocket expenses for home care increase substantially as median family income increases.[16]

---

[14] A Call for Action, p. 93-95. This discussion draws heavily on this report and research published by Robyn Stone, et al., "Caregivers of the Frail Elderly: A National Profile," The Gerontologist, vol. 27, 1987.

[15] This material is drawn largely from Short, Pamela and Joel Leon, "Use of Home and Community Services by Persons Ages 65 and Older with Functional Difficulties," National Medical Expenditure Survey, Research Findings 5, Department of Health and Human Services, Agency for Health Care Policy and Research, September 1990, p. 7-9.

CHART 14. SOURCE OF HOME CARE SERVICES FOR THE SEVERELY DISABLED ELDERLY POPULATION, 1989



Source: Lewin/ICF and the Brookings Institution, 1989 estimates based on National Long-Term Care Survey, 1982.

Note: Severely disabled refers to those persons with three or more ADL limitations.

Public and private spending for long-term care

Table 13 indicates that sizable public and private funds are being spent on long-term care services. For the two major categories of long-term care services, nursing home and home care, total national spending amounted to almost $53 billion in 1988. This total is for all age groups using long-term care. By far the greatest portion of spending is for nursing home care. About $43 billion, or 82 percent of the total, was spent for nursing home care in 1988. This amounted to over 9 percent of total personal health care spending in 1988.

Public programs paid almost 50 percent of the Nation's total nursing home bill. Medicaid payments accounted for almost all of this amount. Medicaid is the Federal-State health program for the poor and for those who have become poor as the result of incurring large medical care expenses. In 1988, Medicaid spending for nursing home care amounted to 45 percent of total national nursing home spending.

---

[16] Liu, Korbin, Kenneth Manton, and Barbara Liu, "Home Care Expenses for the Disabled Elderly," Health Care Financing Review. Winter 1985, vol. 7, No. 2, p. 55.

Table 13 shows that private spending accounted for about $22 billion, or the other half of total spending for nursing home care. Nearly all private spending for nursing home care—94 percent—was paid directly by consumers out-of-pocket with income and/or accumulated resources. Private insurance coverage for long-term nursing home care, a portion of the last line in the table, is very limited, with private insurance payments amounting to 1 percent of total spending for nursing home care in 1988.

By way of contrast, spending for home care services amounted to less than $10 billion, or 18 percent of total long-term care spending. Public programs accounted for about 72 percent of total home care spending. Out-of-pocket payments accounted for almost 80 percent of private spending, private insurance again being very limited for this care. Most home and community-based care, as discussed above, is provided by family and friends who are not paid for the services they provide.

TABLE 13.—NATIONAL LONG-TERM CARE EXPENDITURES, BY SOURCE, 1988

[Dollars in billions]

Source of spending	Amount
Nursing home care:	
Medicaid	$19.2
Medicare	0.8
Other Federal	1.0
Other State	.1
Out-of-pocket payments	20.8
Private insurers and private organizations	1.3
Total	[1] 43.1
Home care:	
Medicaid	3.3
Medicare	2.6
Other Federal programs	0.6
Other State	0.5
Out-of-pocket payments	2.1
Private insurers and private organizations	.6
Total	9.7
Total long-term care expenditures	52.8

[1] Numbers do not total due to rounding.

Source: A Call for Action, The Pepper Commission. Final Report, September 1990. Based on Health Care Financing Administration (HCFA), Department of Health and Human Services, data and Commission staff analysis of unpublished HCFA data.

Major Federal programs supporting long-term care

Five programs represent the major source of Federal financial support available for nursing home and community-based long-term care—Medicaid, Medicare, the Social Services Block Grant (SSBG), the Older Americans Act, and the Supplemental Security Income (SSI) program. None of these programs supports the full range of long-term care services. Certain programs provide health services but exclude social services. Others provide strictly social services. Some have income eligibility requirements, others do not.

Medicaid is the Nation's major program of financial support for long-term care, principally because of its coverage of nursing home care. Medicaid payments for nursing home care (excluding nursing homes for the mentally retarded) amounted to about 30 percent of total Medicaid spending in fiscal year 1989. Comparatively little funding is devoted to home and community-based care. Coverage of both nursing home and home and community-based services is restricted to those persons who have limited income and assets. In general, Medicaid rules limit eligibility to those persons who qualify for cash welfare assistance or who incur large health care expenses that deplete their income and assets.[17]

Medicare, the Federal health insurance program for the elderly and disabled, is focused primarily on coverage for acute health care costs and was never envisioned to provide protection for long-term care. Coverage of nursing home care, for instance, is limited to short-term stays in certain kinds of nursing homes, referred to as skilled nursing facilities, and only for those persons who demonstrate a need for daily skilled nursing care following a hospitalization. Many persons who require long-term nursing home care do not need daily skilled nursing care, and therefore, do not qualify for Medicare's benefit. As a result of this restriction, Medicare paid for about 7.5 percent of the Nation's expenditures for nursing home care in 1989.

For similar reasons, Medicare pays for only limited amounts of community-based long-term care services, primarily through the program's home health benefit. To qualify for home health services, the person must be in need of skilled nursing care on an intermittent basis, or physical or speech therapy. Most chronically impaired persons do not need skilled care to remain in their homes, but rather nonmedical supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel.

Three other Federal programs—SSBG, the Older Americans Act, and the SSI program—provide support for community-based long-term care services for impaired elderly persons. The SSBG provides block grants to the States for a variety of home-based services for the elderly as well as the disabled and children. The Older Americans Act also funds a broad range of in-home services for the elderly. Under the SSI program, the federally administered income assistance program for aged, blind, and disabled persons, many States provide supplemental payments to the basic SSI payment to support selected community-based long-term care services for certain eligible persons, including the frail elderly. However, since funding available for these three programs is limited, their ability to address the financing problems in long-term care is also very limited.

---

[17] Most States extend Medicaid eligibility to persons who qualify for welfare benefits under the Supplemental Security Income (SSI) program. SSI requires that persons have assets that do not exceed $2,000 and income that does not exceed $407 per month in 1991.

Spending down for Medicaid coverage of nursing home care [18]

As discussed above, the Medicaid program is the major public source of support for the costs of nursing home care. Its spending for nursing home care is driven largely by its coverage of persons who are not initially poor but who become poor by depleting their assets and income on the cost of their care. Currently nursing home care costs on average $30,000 per year. The depletion of assets and income and movement from private payment for care to Medicaid coverage is referred to as the "spend-down" process. In 1988, Medicaid nursing home payments for elderly persons who spent down amounted to almost 60 percent of total Medicaid payments for all services for all elderly beneficiaries.[19]

Only very limited information, generally in the form of case studies, is available about how many persons spend down and how long it takes them to do so. No national data base exists that captures the utilization of nursing home care over time and the point at which Medicaid becomes the primary source of payment for that care. As a result, definitive answers are not available for questions about how large the spend-down population is, how long it takes for them to spend down, and whether spend-down occurs after nursing home stays of a given length, or in conjunction with the need for other health care services.

GAO Study.—A 1983 GAO report, "Medicaid and Nursing Home Care," found in its review of a number of studies and its own analysis of one State's data that one-quarter to two-thirds of Medicaid residents of nursing homes entered as private paying patients and subsequently converted to Medicaid.[20] GAO also found that higher proportions of residents with longer nursing home stays were supported by Medicaid than those with shorter stays.

---

[18] This material draws heavily on Characterisitics of Nursing Home Residents and Proposals for Reforming Coverage of Nursing Home Care, p. 82-90.

[19] Spending down under Medicaid is a two-step process. First, persons must meet the resources or assets test. The term "resources" generally refers to liquid assets such as cash on hand, savings and checking accounts, stocks, bonds, etc, as well as real and personal property. In order to become eligible for Medicaid, the value of the individual's available resources must be less than a State-determined dollar standard, usually $2,000 for an individual without a spouse, the level used for the SSI program. Certain items, such as the house, are excluded as countable resources under SSI and Medicaid rules. Second, after an individual has depleted virtually all accumulated resources on the cost of nursing home care, or has transferred resources (for less than fair market value) prior to the time when eligibility could be denied because of the transfer, income standards are then considered. Most States have no absolute upper limit on income for applicants residing in nursing homes. These States have what are known as medically needy programs. As long as the applicant's current monthly income is insufficient to cover medical expenses, including the cost of care in the nursing home, the applicant can become eligible for Medicaid. However, income in excess of amounts that are disregarded for personal needs and other purposes must be applied to the cost of care. A number of other States use a special income level to determine eligibility for persons residing in nursing homes. These persons are referred to as noncash categorically needy, and like the medically needy, have income in excess of cash welfare program standards. By Federal law, the special income level used by States can be no more than three times the basic SSI payment level, or $1,221 in 1991. This rule is known as the "300 percent rule."

[20] U.S. General Accounting Office. "Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly." GAO/IPE-84-1, October 21, 1983. p. 25-26.

Michigan study.—A study analyzing Medicaid nursing home data for the State of Michigan provides some useful information about the extent to which persons changed to Medicaid during the course of their nursing home stay in that State. This study analyzed information for all elderly nursing home users who received Medicaid in the State in 1984.[21] For all persons using nursing home care that Medicaid paid for in 1984, slightly more than one quarter (27.2 percent) of elderly Medicaid enrollees originally entered as private pay patients. Elderly persons who were enrolled in Medicaid before admission amounted to 37.5 percent, and those who enrolled at admission (within the same month) comprised the remaining 35 percent.[22] Relatively few of those elderly persons who spent down had short stays in the nursing home. Less than 4 percent of those who spent down had nursing home stays of less than 3 months in length. In contrast, almost three-fourths of those who spent down had total nursing home stays of longer than a year. For the 27.5 percent who spent down in the nursing home, approximately 38 percent took less than 90 days to convert to Medicaid, and about 55 percent converted within 6 months. About 26 percent took 1 year or more to spend down and qualify for Medicaid, and 11 percent took 2 years or more.[23]

National Long-Term Care Surveys.—Analysis of data from the 1982 and 1984 National Long-Term Care Surveys (NLTCS) has also shed light on the likelihood of spend-down for those persons using nursing home care. The NLTCS were designed to provide longitudinal information about a nationally representative sample of elderly Medicare beneficiaries who were residing in the community in 1982 and who needed long-term assistance (90 days or more) with one or more ADLs or IADLs. Analysis of survey data has shown that about 12 percent of the 1982 community residents spent some time in a nursing home in the 1982–1984 period. Approximately 31 percent of persons using nursing home care became Medicaid eligible during the period, in contrast to only 7 percent for those who did not use nursing home care during the period. Only 7 percent of those persons who entered a nursing home for a temporary or short stay were Medicaid eligible in 1984, as opposed to 41 percent of those who were in the nursing home care for long stays.[24]

House Aging Committee study.—Another analysis published by the House of Representatives Select Committee on Aging provided estimates of the length of time of spend-down and the risk of impoverishment for elderly persons needing long-term care services. This study used a microsimulation model of income and assets of the elderly, developed by the Urban Institute, together with data from the Medicare and Medicaid programs on the cost of long-term care services, to estimate the length of time in which elderly persons using long-term care services would spend down to the Federal poverty level. The study estimated that 70 percent of elderly persons living alone would spend down their income to the Federal poverty level after 13 weeks in a nursing home, and over 90 percent would be impoverished within 1 year of admission. If both income and assets were considered, nearly one-half of elderly persons living alone would be impoverished after 13 weeks in a nursing home and approximately two-thirds would be impoverished within 1 year. For couples, 34 percent would be impoverished after one spouse had spent 13 weeks in a nursing home and almost 80 percent would be impoverished within 1 year when income alone was considered. When both income and assets were taken into account, almost one-half of couples would be impoverished after 1 year in a nursing home.[25]

---

[21] It should be noted that this study's analysis is limited to data for elderly nursing home users who eventually became enrolled in Medicaid. The data exclude elderly persons who entered nursing homes as private pay patients and remained private pay throughout the period examined.

[22] Burwell, Brian O., et al. "Spend-Down of Assets Before Medicaid Eligibility Among Elderly Nursing-Home Recipients in Michigan" Medical Care, vol. 28, No. 4, April 1990. p. 353.

[23] Ibid., p. 356.

[24] Liu, Korbin and Kenneth Manton. "The Effect of Nursing Home Use on Medicaid Eligibility." The Gerontologist, vol. 29, No. 1, 1989. p. 63–64.

1985 National Nursing Home Survey (NNHS).—The 1985 NNHS collected information on an individual's payment source at admission as well as at the time of the interview or discharge from the nursing home. It did not, however, collect information on the specific point in time when the primary payment source changed, if it did. Therefore, with the NNHS, it is not possible to study the spend-down process directly. It is possible, however, to show what share of the nursing home population relied on more than one source of payment and whether persons shifted from one source of payment to another.

For this analysis, the discharged nursing home population was divided into two groups: those who were non-Medicaid during the course of their entire stay and those who used Medicaid as a source of payment during at least some portion of their stay. The non-Medicaid group consists of those persons who use Medicare, own income, family income, other support such as Veterans Administration, or some combination of these as payment sources for the cost of their care. As chart 15 indicates, this group amounted to 55 percent of those discharged from nursing homes. In other words, a large proportion of those persons discharged from nursing homes never used Medicaid as a payment source for their stays.

The remaining 45 percent of total discharges used Medicaid during their stay. The Medicaid group consists of two subgroups. The larger of these are persons who were Medicaid eligible at admission to the nursing home. They amounted to 38 percent of total discharges. Those who became Medicaid eligible during the course of their stay comprise only 7 percent of total discharges. This latter group is the spend-down population, as measured by the NNHS. These are persons who during their stay depleted their assets to levels required under State Medicaid plans.

A number of observations need to be made about these Medicaid categories. First, NNHS data do not permit analysis of the circumstances under which those who used Medicaid at admission initially became eligible for Medicaid. This group would include persons who were Medicaid eligible because they received cash welfare benefits. It could also include those persons who had previously spent down assets on previous nursing home stays or on other health care expenses. Therefore, the spend-down population as measured by the NNHS may actually be larger than the 7 percent indicated in chart 15.

---

[25] U.S. Congress. House. Select Committee on Aging. "Long Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are At Risk." Pub. No. 100-631. Washington, U.S. Govt. Print. Off., October 1987. Note that this study uses the Federal poverty level for estimating impoverishment, rather than Medicaid standards which are generally lower than Federal poverty guidelines. In 1988, Congress amended Medicaid to protect larger amounts of income and assets for the community spouse of a nursing home resident eligible for Medicaid.

Chart 16 provides the median length of stay for persons discharged from nursing homes, by each of four payment categories: (1) Medicare; (2) other non-Medicaid sources of payment, including own income, family income, and other resources; (3) Medicaid as a payment source during admission month; and (4) the spend-down population, i.e., individuals who did not use Medicaid as a payment source during their admission but did use Medicaid during their discharge month.

Residents using Medicare and "other" had the shortest median lengths of stay, 21 days and 64 days, respectively. Those with Medicaid at admission had a median length of stay of 165 days. The spend-down population had the longest median stay—335 days.

CHART 15. NURSING HOME DISCHARGED RESIDENTS, BY MEDICAID PAYMENT SOURCE, 1984–85

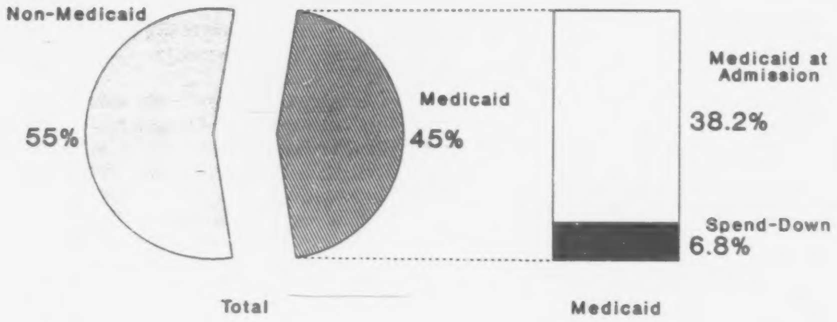
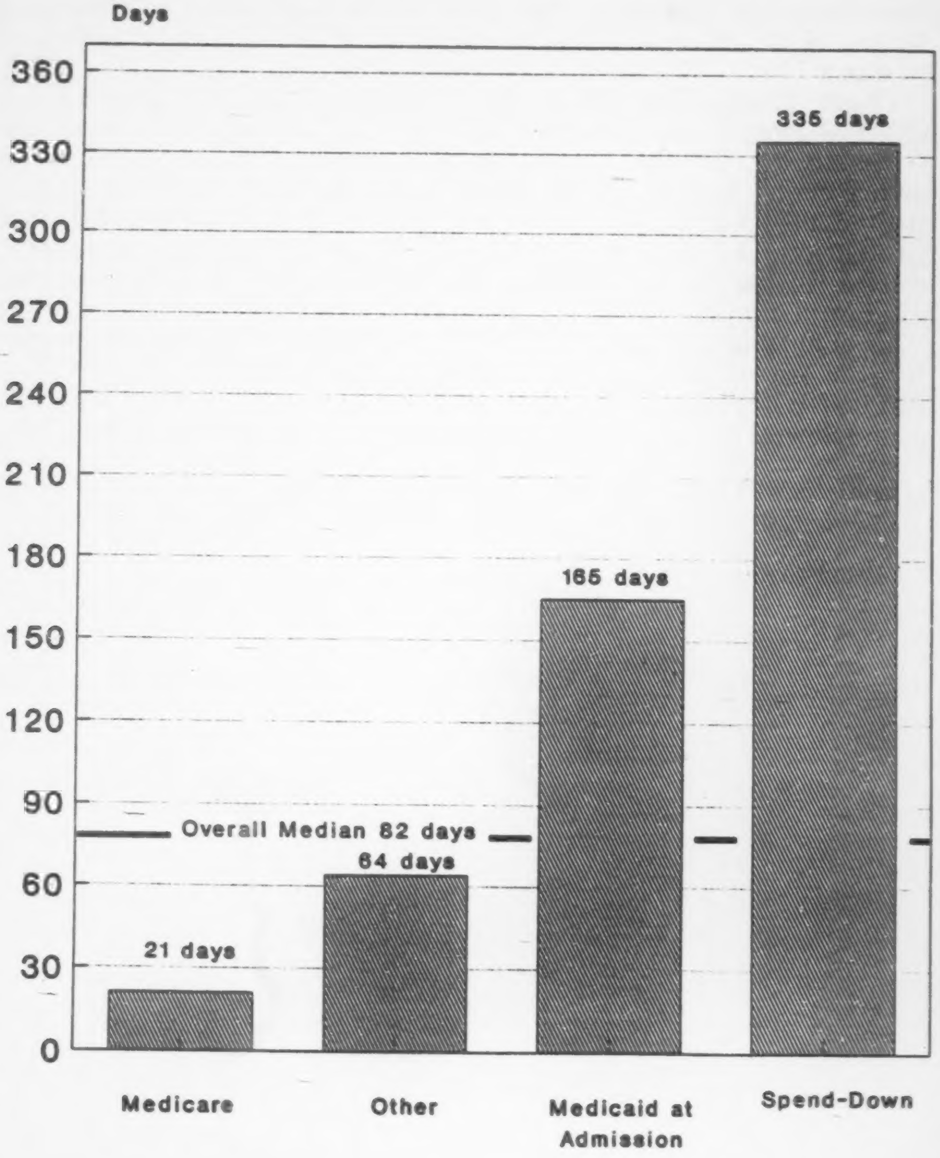


CHART 16. MEDIAN LENGTH OF STAY, BY PAYMENT CATEGORY, 1984–85



Private long-term care insurance

Private long-term care insurance is generally considered to be the most promising private sector option for providing the elderly additional protection for long-term care expenses. Long-term care insurance is a relatively new, but rapidly growing, market. In 1986, approximately 30 insurers were selling long-term care insurance policies of some type and an estimated 200,000 persons were covered by these policies. By 1987, a Department of Health and Human Services Task Force on Long-Term Care Insurance found

73 companies writing long-term care insurance policies covering 423,000 persons. As of June 1990, the Health Insurance Association of America found that more than 1.65 million policies had been sold, with 134 insurers offering coverage.

Although growth has been considerable in a short period of time, the private insurance industry has approached this potential market with caution. Insurers are concerned about the potential for adverse selection in long-term care insurance, where only those persons likely to need care actually buying insurance. In addition, they point to the problem of induced demand for services that can be expected to be generated by the availability of new long-term care insurance. With induced demand, sometimes also referred to as moral hazard, individuals decide to use more services than they othewise would because they have insurance and/or will shift from nonpaid to paid providers for their care. In addition, insurers are concerned that, given the nature of many chronic conditions, persons who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

As a result of these risks, insurers have designed policies that limit their liability for paying claims. Policies have been medically underwritten to exclude persons with certain conditions or illnesses. They have contained benefit restrictions that limit access to covered care. Policies also limit the period of coverage they offer, typically to a maximum of 4 or 5 years. In addition, most plans provide indemnity benefits that pay only a fixed amount for each day of coverage service. If these amounts are not updated for inflation, the protection offered by the policy can be signficantly eroded by the time a person actually needs care. Today payment amounts can generally be updated for inflation, but only with significant increases in premium costs.

These design features of long-term care insurance raise issues about the quality of coverage offered purchasers of policies. The insurance industry has responded to some of these concerns by offering new products that provide broadened coverage and fewer restrictions. One of the key issues outstanding in the debate on the role private insurance can play in financing long-term care is the affordability of coverage. The Health Insurance Association of America has reported that policies paying $80 a day for nursing home care and $40 a day for home health care with inflation protection and a 20-day deductible period and a 4-year maximum coverage period had an average annual premium in 1989 of $1,395 when purchased at the age of 65 and $4,199 when purchased at the age of 79.[26] Many elderly persons cannot afford these premiums.

The insurance industry believes that affordability of premiums can be greatly enhanced if the pool of persons to whom policies are sold is expanded. The industry has argued that the greatest potential for expanding the pool of persons buying coverage and reducing premiums lies with employer-based group coverage. Premiums should be lower in employer-based group coverage because younger age groups with lower levels of risk of needing long-term care would be included, allowing insurance companies to build up reserves to cover future payments of benefits. In addition, group coverge has lower administrative expenses.

---

[26] "Long-Term Care Insurance: A Market Update." Research Bulletin, January 1991. p. 18.

As of June 1990, 153 employers had agreed to offer a long-term care insurance plan to their employees; 54 plans became effective in 1989 and the remaining 99 were scheduled to become effective in 1990 or 1991.[27] By June 1990, about 79,500 persons were enrolled in employer-sponsored long-term care plans. About 60 percent of these enrollees were active employees and their spouses and the other 40 percent were retirees and their spouses, parents and parents-in-law.

But just how broadly based employer interest is in a new long-term care benefit is unclear at the present. Many employers currently face large unfunded liabilities for retiree pension and health benefits. Also, many employers have recently experienced fairly substantial increases in premiums for their current health benefits plans. Currently only three employers contribute to the cost of a long-term care plan. Other employers require that the employee pay the full premium cost of coverage. In contrast, the majority of medium and large sized employers pay the full premium cost of regular health care benefits for their employees.

---

[27] Ibid, p. 22.

APPENDIX C. NATIONAL AND INTERNATIONAL HEALTH CARE EXPENDITURES AND HEALTH INSURANCE COVERAGE

National Health Expenditures

During 1965 (the year prior to the beginning of the Medicare and Medicaid programs), national health expenditures were $41.6 billion; by 1989, annual expenditures were $604.1 billion, over 14 times that amount (see table 1). Hospital care expenditures are the largest component of national health expenditures, representing 39 percent of total national health spending in 1989. In terms of per capita spending, $907 was spent for hospital care in 1989 compared to $680 in 1985, an increase of 33.4 percent over 4 years (see table 3).

Data in this section are based on the latest revisions in the national cost estimates developed by the Office of the Actuary, Health Care Financing Administration. Last year, the Office made significant changes in the methodology used for these estimates, and it retroactively revised the figures from 1960 to the present. Among the most significant changes are shifts of certain types of expenditures from physician services to other categories, and a reduction in estimates of out-of-pocket payments by individuals.

Adjusting for inflation, health care expenditures have still increased substantially, rising from $163.8 billion in 1965 (in constant 1989 dollars) to $604.1 billion in 1989, an increase of about 269 percent (see table 2). The largest increases occurred between 1965 and 1970 (44 percent) and 1980 to 1985 (29 percent). The same trends are found when per capita expenditures are examined. The annual rate of increase in the 1980–85 period was 4.2 percent. For the years 1986–89, the annual rate of increase has risen slightly, to 4.7 percent.

Of the various sources of payment for personal health care expenditures in 1989, 32.6 percent ($172.9 billion) was paid by private health insurance, 29.8 percent ($158.4 billion) was paid by Federal sources (including Medicare and Medicaid), 10.8 percent ($57.0 billion) was paid by State and local sources, and 23.6 percent ($124.8 billion) was paid by direct (out-of-pocket) payments by individuals. A little over 3 percent was paid by philanthropy and in-plant health services (see table 5).

TABLE 1.—NATIONAL HEALTH EXPENDITURES: AGGREGATE AMOUNTS FOR SELECTED CALENDAR YEARS 1960–1989

[Dollar amounts in billions]

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989
Total	$27.1	$41.6	$74.4	$132.9	$249.1	$420.1	$452.3	$492.5	$544.0	$604.1
Percent of GNP	5.3	5.9	7.3	8.3	9.1	10.5	10.7	10.9	11.2	11.6
Health services and supplies	$25.4	$38.2	$69.1	$124.7	$237.8	$404.7	$436.3	$475.2	$524.1	$583.5
Personal health care	23.9	35.6	64.9	116.6	218.3	367.2	398.2	436.7	480.0	530.7
Hospital care	9.3	14.0	27.9	52.4	102.4	167.9	179.4	193.8	211.7	232.8
Physicians' services	5.3	8.2	13.6	23.3	41.9	74.0	82.1	93.0	105.1	117.6
Dentists' services	2.0	2.8	4.7	8.2	14.4	23.3	24.7	27.1	29.4	31.4
Other professional services	.6	.9	1.5	3.5	8.7	16.6	18.6	21.2	23.8	27.0
Home health care	.0	.1	.1	.4	1.3	3.8	4.0	4.1	4.5	5.4
Drugs and other medical nondurables	4.2	5.9	8.8	13.0	20.1	32.3	35.6	38.7	41.5	44.6
Vision products and other medical durables	.8	1.2	2.0	3.1	5.0	8.4	9.5	10.7	12.0	13.5
Nursing home care	1.0	1.7	4.9	9.9	20.0	34.1	36.7	39.8	42.8	47.9
Other personal health care	.7	.8	1.4	2.7	4.6	6.8	7.6	8.3	9.3	10.5
Program administration and net cost of private health insurance	1.2	1.9	2.8	5.1	12.2	25.2	24.7	23.9	27.9	35.3
Government public health activities	.4	.6	1.4	3.0	7.2	12.3	13.5	14.7	16.2	17.5
Research, and construction of medical facilities	1.7	3.5	5.3	8.3	11.3	15.4	16.0	17.3	19.8	20.6

Note: Totals may not add due to rounding.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

TABLE 2.—NATIONAL HEALTH EXPENDITURES: IN CONSTANT 1989 DOLLARS, FOR SELECTED CALENDAR YEARS 1960–89

[Dollar amounts in billions]

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989
Total	$113.8	$163.8	$237.7	$306.4	$374.8	$484.1	$511.7	$537.6	$570.2	$604.1
Health services and supplies	106.7	150.2	220.7	287.3	357.8	466.3	493.7	518.7	549.4	583.5
Personal health care	100.2	140.2	207.4	268.7	328.6	423.1	450.5	476.6	503.2	530.7
Hospital care	38.9	55.3	89.3	120.8	154.1	193.5	203.0	211.5	221.9	232.8
Physicians' services	22.2	32.2	43.4	53.6	63.0	85.2	92.8	101.5	110.2	117.6
Dentists' services	8.2	11.0	14.9	19.0	21.6	26.8	28.0	29.6	30.8	31.4
Other professional services	2.5	3.4	4.8	8.1	13.1	19.2	21.1	23.1	24.9	27.0
Home health care	0.2	0.2	0.5	0.9	2.0	4.4	4.5	4.5	4.7	5.4
Drugs and other medical nondurables	17.8	23.2	28.2	30.0	30.3	37.2	40.2	42.2	43.5	44.6
Vision products and other medical durables	3.4	4.9	6.5	7.1	7.5	9.6	10.8	11.7	12.5	13.5
Nursing home care	4.1	6.7	15.6	22.9	30.1	39.3	41.5	43.4	44.9	47.9
Other personal health care	2.9	3.2	4.4	6.2	6.9	7.9	8.6	9.1	9.7	10.5
Program administration and net cost of private health insurance	4.9	7.6	8.8	11.7	18.4	29.0	27.9	26.1	29.3	35.3
Government public health activities	1.6	2.5	4.4	7.0	10.9	14.2	15.3	16.0	17.0	17.5
Research, and construction of medical facilities	7.1	13.6	17.0	19.1	17.0	17.7	18.1	18.9	20.8	20.6

Note: Constant dollar expenditures are calculated using the consumer price index for all urban consumers (CPI–U).

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

TABLE 3.—NATIONAL HEALTH EXPENDITURES: PER CAPITA AMOUNTS FOR SELECTED CALENDAR YEARS 1960–89

[Dollar amounts per capita]

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989
Total	$143	$204	$346	$592	$1,059	$1,700	$1,813	$1,955	$2,139	$2,354
Health services and supplies	134	187	321	555	1,011	1,638	1,749	1,887	2,061	2,274
Personal health care	126	175	302	519	928	1,486	1,596	1,734	1,888	2,068
Hospital care	49	69	130	233	435	680	719	769	833	907
Physicians' services	28	40	63	104	178	299	329	369	413	458
Dentists' services	10	14	22	37	61	94	99	108	116	122
Other professional services	3	4	7	16	37	67	75	84	93	105
Home health care	0	0	1	2	6	16	16	16	18	21
Drugs and other medical nondurables	22	29	41	58	86	131	143	154	163	174
Vision products and other medical durables	4	6	9	14	21	34	38	42	47	53
Nursing home care	5	8	23	44	85	138	147	158	168	187
Other personal health care	4	4	6	12	19	28	30	33	37	41
Program administration and net cost of private health insurance	6	9	13	23	52	102	99	95	110	138
Government public health activities	2	3	6	14	31	50	54	58	64	68
Research, and construction of medical facilities	9	17	25	37	48	62	64	69	78	80

Note: Totals may not add due to rounding.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

TABLE 4.—NATIONAL HEALTH EXPENDITURES: PER CAPITA AMOUNTS, IN CONSTANT 1989 DOLLARS, FOR SELECTED CALENDAR YEARS 1960–89

[Dollar amount per capita]

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989
Total	$599	$803	$1,106	$1,364	$1,593	$1,959	$2,052	$2,134	$2,243	$2,354
Health services and supplies	561	736	1,027	1,279	1,521	1,888	1,979	2,060	2,161	2,274
Personal health care	527	687	965	1,196	1,397	1,713	1,806	1,892	1,979	2,068
Hospital care	205	271	415	538	655	783	814	840	873	907
Physicians' services	117	158	202	239	268	345	372	403	433	458
Dentists' services	43	54	69	85	92	108	112	118	121	122
Other professional services	13	17	23	36	56	78	84	92	98	105
Home health care	1	1	2	4	9	18	18	18	19	21
Drugs and other medical nondurables	94	114	131	134	129	150	161	168	171	174
Vision products and other medical durables	18	24	30	32	32	39	43	46	49	53
Nursing home care	22	33	72	102	128	159	167	172	176	187
Other personal health care	15	16	20	28	29	32	34	36	38	41
Program administration and net cost of private health insurance	26	37	41	52	78	117	112	104	115	138
Government public health activities	8	12	21	31	46	57	61	63	67	68
Research, and construction of medical facilities	37	67	79	85	72	72	72	75	82	80

Average annual [percentage increase]	60–65	65–70	70–75	75–80	80–85	60–89	85–89	88–89
Total	6.0	6.6	4.3	3.2	4.2	4.8	4.7	5.0
Health services and supplies	5.6	6.9	4.5	3.5	4.4	4.9	4.8	5.2
Personal health care	5.4	7.0	4.4	3.2	4.2	4.8	4.8	4.5
Hospital care	5.8	8.9	5.3	4.0	3.6	5.3	3.7	3.9
Physicians' services	6.3	5.0	3.4	2.3	5.2	4.8	7.4	5.8

Note: Constant dollar expenditures are calculated using the consumer price indices for all urban consumers (CPI-U).

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

TABLE 5.—PERSONAL HEALTH CARE EXPENDITURES: AGGREGATE AMOUNTS AND PERCENTAGE DISTRIBUTION FOR SELECTED CALENDAR YEARS 1960–1989

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989
	Amount in billions of dollars									
Total	$23.9	$35.6	$64.9	$116.6	$218.3	$367.2	$398.2	$436.7	$480.0	$530.7
Private	18.8	28.4	42.5	71.3	131.3	218.7	236.2	258.8	287.4	315.3
Private health insurance	5.0	8.7	15.2	29.9	65.3	114.1	125.2	139.4	155.9	172.9
Out of pocket	13.4	19.0	25.6	38.5	58.4	91.7	97.4	104.7	115.5	124.8
Other private sources of funds	.4	.7	1.7	2.9	7.6	12.9	13.5	14.7	16.0	17.6
Public	5.1	7.3	22.4	45.3	87.1	148.5	162.0	177.8	192.7	215.4
Federal	2.1	3.0	14.6	31.0	63.5	111.6	120.2	130.3	141.7	158.4
State and local	3.0	4.3	7.8	14.4	23.6	36.9	41.7	47.5	51.0	57.0
	Percentage distribution									
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	78.6	79.6	65.4	61.1	60.1	59.6	59.3	59.3	59.9	59.4
Private health insurance	21.0	24.3	23.4	25.6	29.9	31.1	31.5	31.9	32.5	32.6
Out of pocket	55.9	53.4	39.5	33.1	26.8	25.0	24.5	24.0	24.1	23.5
Other private sources of funds	1.7	1.9	2.6	2.5	3.5	3.5	3.4	3.4	3.3	3.3
Public	21.4	20.4	34.6	38.9	39.9	40.4	40.7	40.7	40.1	40.6
Federal	8.9	8.3	22.6	26.6	29.1	30.4	30.2	29.8	29.5	29.8
State and local	12.5	12.0	12.0	12.3	10.8	10.0	10.5	10.9	10.6	10.7

Note: Totals may not add due to rounding.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

EXPENDITURES FOR HOSPITAL CARE

The American Hospital Association (AHA) compiles detailed measures of expenses (expenditures) of the Nation's community hospitals, which are defined as all non-Federal short-term general and other special hospitals (excluding, after 1971, hospital units of institutions) whose facilities and services are available to the public. Table 6 shows historical expense data for community hospitals from the AHA's National Hospital Panel Survey. The Survey is a monthly survey of a randomly selected sample of about 1,800 of the approximately 5,800 community hospitals.

The total expenses of community hospitals, including expenses for both inpatient and outpatient care, were $217.1 billion in 1990, an increase of 174 percent over the preceding 10 years. The average cost of a day of hospital care was $765 in 1990, representing a 10-year increase of 199 percent. The increase in hospital inpatient costs per admission, or "cost per case" over the past 10 years was 174 percent, rising to $5,021 in 1990 (see table 6).

Table 6 displays, for measures of hospital expense, data for the years 1965 to 1990. The rate of growth in hospital expenses exceeded the rate of inflation, as measured by the CPI, in most years. Until recently, changes in the rate of growth in hospital expenses followed changes in inflation. For example, the medical care component of the CPI and the rates of growth in the adjusted expenses per inpatient day and per admission were all relatively low during the Economic Stabilization Program (August 1971 through 1974). Also, the rates of increase of all four measures of community hospital expenses followed the CPI downward between 1981 and 1984. However, since 1984, hospital expenses have continued to go up, even as inflation has slowed. (A short-term downward trend in the growth rate of hospital expenses which is not reflected in the CPI indexes is evident in the 1976 to 1979 interval. Some analysts have argued that this was due perhaps in part to the initiation in 1978 of a "voluntary effort" to reduce health care costs initiated by the American Hospital Association and other health organizations.)

TABLE 6.—SELECTED COMMUNITY HOSPITAL EXPENSES DATA, TOTALS AND PERCENTAGE INCREASES, 1965–90

[Dollars in billions]

Year	Total expenses		Adjusted [1] expenses per inpatient day		Adjusted expenses per admission		Inpatient expenses	
	Amount	Percent change	Amount	Percent change	Amount	Percent change	Amount	Percent change
1965	$9.220	8.6	$41	7.5	$315	8.1	$8.414	8.7
1966	10.497	13.8	46	12.2	356	13.0	9.611	14.2
1967	12.624	20.3	53	15.2	425	19.4	11.551	20.2
1968	14.720	16.6	59	11.3	482	13.4	13.371	15.8
1969	17.247	17.2	68	15.2	551	14.3	15.635	16.9
1970	20.261	17.5	78	14.7	608	10.3	18.328	17.2
1971	22.496	11.0	87	11.5	670	10.2	20.269	10.6
1972	25.223	12.1	96	10.3	729	8.8	22.622	11.6
1973	28.248	12.0	105	9.4	784	7.5	25.173	11.3
1974	32.759	16.0	118	12.4	873	11.4	29.077	15.5
1975	38.492	17.5	138	16.9	1,017	16.5	33.971	16.8
1976	45.842	19.1	158	14.5	1,168	14.8	40.321	18.7
1977	53.006	15.6	181	14.5	1,312	12.3	46.437	15.2
1978	59.802	12.8	203	12.2	1,466	11.7	52.131	12.3
1979	67.833	13.4	226	11.3	1,618	10.4	59.060	13.3
1980	79.340	17.0	256	13.3	1,836	13.5	68.962	16.8
1981	94.187	18.7	299	16.8	2,155	17.4	81.651	18.4
1982	109.091	15.8	348	16.4	2,489	15.5	94.346	15.5
1983	120.220	10.2	391	12.5	2,742	10.2	103.403	9.5
1984	126.028	4.6	443	13.3	2,947	7.5	107.000	3.2
1985	134.043	6.6	493	11.2	3,226	9.4	111.402	4.4
1986	146.032	8.9	535	8.6	3,527	9.3	119.281	7.1
1987	161.322	10.5	581	8.6	3,860	9.5	129.300	8.4
1988	177.770	10.2	632	8.8	4,194	8.6	140.482	8.2
1989	195.377	9.9	690	9.3	4,586	9.3	152.147	8.3
1990	217.113	11.1	765	10.7	5,021	9.5	165.792	9.0

[1] Adjusted to account for the volume of outpatient visits.

Note: Percentage changes may not correspond to published data because of rounding.

Source: National Hospital Panel Survey, American Hospital Association.

A variety of factors other than overall inflation contribute to aggregate changes in hospital expenses, including: population growth, aging of the population, which affects admission rates, inflation over and above general inflation in the prices of goods and services purchased by the hospitals (input factor prices), and changes in the type and mix (intensity) of services rendered due to such factors as changes in the use of technology or treatment patterns. Arnett et al. (Health Care Financing Review, spring 1986) estimated that over 51 percent of the overall growth in inpatient hospital expenses between 1974 and 1984 was due to overall inflation, approximately

7.3 percent to population growth, 16.6 percent to excess inflation in hospital prices, and 33.4 percent to intensity of services per day.

Expenditures for hospital care are financed primarily by third parties (see table 7). In 1989, private health insurers paid 36.2 percent of the total, Medicare and Medicaid paid 36.6 percent, and other government programs paid 17.0 percent. The amount financed out-of-pocket by consumers was an estimated 5.5 percent. This estimate, and those for earlier years, are much lower than those previously published, because of changes in the methodology used by the Office of the Actuary. For example, out-of-pocket spending for 1987 was previously estimated at $18.5 billion, and is now estimated to have been $8.7 billion.

Table 7 also shows that the Medicare share of spending dropped steadily from 1985 to 1989, the first such decreases since the early 1970s. HCFA attributed this decline to the relatively low growth in Medicare payments per hospital admission.

TABLE 7.—EXPENDITURES FOR HOSPITAL CARE, BY SOURCE OF FUNDS, 1980 AND 1985–89

[Amounts in billions of dollars]

Source of payment	1980		1985		1986		1987		1988		1989	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$102.4	100.0	$167.9	100.0	$179.4	100.0	$193.8	100.0	$211.7	100.0	$232.8	100.0
Out of pocket	5.3	5.2	8.8	5.2	8.6	4.8	8.7	4.5	11.3	5.3	12.7	5.5
Third-party payments	97.1	94.8	159.1	94.8	170.8	95.2	185.1	95.5	200.4	94.7	220.1	94.5
Private health insurance	37.5	36.6	59.5	35.4	63.8	35.6	69.5	35.8	76.2	36.0	84.2	36.2
Other private funds	5.0	4.9	8.2	4.9	8.6	4.8	9.4	4.9	10.3	4.9	11.4	4.9
Government	54.6	53.3	91.4	54.4	98.3	54.8	106.2	54.8	113.9	53.8	124.5	53.5
Federal	41.3	40.4	71.5	42.5	75.4	42.0	80.1	41.3	85.7	40.5	92.9	39.9
Medicare	26.4	25.8	48.5	28.9	50.9	28.3	53.7	27.7	57.5	27.2	62.1	26.7
Medicaid [1]	5.3	5.2	8.4	5.0	9.2	5.1	10.1	5.2	11.2	5.3	12.9	5.6
Other Federal programs	9.7	9.4	14.5	8.6	15.4	8.6	16.3	8.4	17.0	8.0	17.9	7.7
State and local	13.3	12.9	19.9	11.9	23.0	12.8	26.0	13.4	28.2	13.3	31.6	13.6
Medicaid [2]	4.4	4.3	7.1	4.2	7.4	4.1	8.5	4.4	8.8	4.2	10.0	4.3
Other State and local programs	8.9	8.7	12.9	7.7	15.6	8.7	17.6	9.1	19.3	9.1	21.6	9.3

---

[1] Federal share only.

[2] State share only.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

TRENDS IN HOSPITAL UTILIZATION

Length of stay

Before the implementation of Medicare's prospective payment system (PPS), length of stay (LOS) was generally decreasing (table 8). The introduction of PPS accelerated this decline, producing a dramatic and measurable change in patient care. However, lengths of stay have been stable for the last several years. This may mean that hospitals have reached the limits of their ability to substitute preadmission and postdischarge services for inpatient services. The trends for the Medicare population (adults over 65) are similar to those for all adults.

Admissions

From 1978 to 1983, total admissions increased an average 1.2 percent a year, and 4.8 percent per year for the over-age-65 population (see table 9). From 1982 on, admissions declined for the under-age-65 population. A marked decrease in the over-age-65 admissions occurred when PPS was introduced, although this was unexpected. However, from 1987 to 1989 admissions for those over age 65 have increased slightly. Decreases in the early years of PPS may represent a period of adjustment in hospital admitting patterns.

Hospital employment

Hospitals experienced a significant downturn in total employment levels at the time PPS was introduced (see table 10). After declining 2.3 percent in both 1984 and 1985, however, total hospital employment is once again increasing. This most recent growth resulted largely from increased employment in the outpatient area. Hospitals continue to employ an increasing number of personnel, both full time and part time. In recent years, however, the growth in the number of part-time personnel has been greater than the growth in the number of full-time personnel.

Hospital occupancy

Hospital occupancy rates declined in the early 1980's through 1986 (see table 11). In 1987, 1988, and 1989, occupancy rates increased slightly, but remain well below pre-PPS levels. This increase in occupancy rates is due at least in part to the continued decline in the number of beds.

TABLE 8.—CHANGE IN LENGTH OF STAY, ALL ADULTS AND ADULTS OVER AGE 65, 1978–90

Year	All adults length of stay	Percent change	Age 65 and over	Percent change
1978	7.2	−0.3	10.6	−1.2
1979	7.1	−1.1	10.4	−1.9
1980	7.2	.6	10.4	−.1
1981	7.2	.4	10.4	−.1
1982	7.2	−.7	10.1	−2.3
1983	7.0	−2.0	9.7	−4.4
1984	6.7	−5.1	9.0	−7.5
1985	6.6	−1.7	8.8	−2.1
1986	6.6	.6	8.8	.4
1987	6.6	.8	8.9	1.0
1988	6.6	0	8.8	−.7
1989	6.6	0	8.8	0
1990[1]	6.6	0	8.7	−1.1
Average annual change:				
1978–1983	7.1	−.5	10.3	−1.7
1984–1990	6.6	−.8	8.8	−1.5

[1] Estimate based on January through November 1990 compared with January through November 1989.

Source: American Hospital Association National Panel Survey.

TABLE 9.—PERCENT CHANGE IN HOSPITAL ADMISSIONS, 1978–90

Year	Admissions		
	All	Under age 65	Age 65 and over
1978	0.4	−1.0	4.9
1979	2.7	1.7	5.3
1980	2.9	1.5	6.7
1981	.9	0	3.0
1982	0	−1.6	4.1
1983	−.5	−2.8	4.7
1984	−3.7	−4.2	−2.6
1985	−4.9	−4.7	−5.2
1986	−2.1	−2.5	−1.0
1987	−.6	−1.0	.4
1988	−.4	−1.6	2.0
1989	−1.1	−2.0	1.2
1990[1]	−.2	−1.3	2.1
Average annual change:			
1978–83	1.2	−.2	4.8
1984–90	−1.9	−2.5	−.5

[1] Estimate based on January through November 1990 compared with January through November 1989.

Source: American Hospital Association National Panel Survey.

TABLE 10.—PERCENT CHANGE IN HOSPITAL EMPLOYMENT, 1978–89

Year	Total hospital FTE's	Inpatient FTE's	Personnel		
			Total	Full time	Part time
1978	3.7	3.2	4.1	3.3	6.8
1979	3.5	3.3	3.9	3.0	6.7
1980	4.7	4.5	5.2	4.0	9.1
1981	5.4	5.1	6.0	4.8	9.4
1982	3.7	3.4	3.7	3.6	4.1
1983	1.4	.8	1.5	1.2	2.3
1984	−2.3	−3.5	−2.1	−2.6	−.8
1985	−2.3	−4.3	−1.8	−2.7	−.1
1986	.3	−1.4	.4	.3	.7
1987	.7	−.7	.9	.4	2.3
1988	1.1	−.7	1.4	.7	3.3
1989	1.6	.1	1.9	1.2	3.6
1990[1]	2.3	−.4	2.5	1.9	4.0
Average annual change:					
1978–83	3.7	3.4	4.1	3.3	6.4
1984–90	.2	−1.6	.4	−.1	1.8

[1] Estimate based on January through November 1990 compared with January through November 1989.

Source: American Hospital Association National Hospital Panel Survey.

TABLE 11.—CHANGE IN INPATIENT HOSPITAL OCCUPANCY RATES AND NUMBERS OF BEDS, 1978–89

Year	Percent		Number of beds	Percent change
	Occupancy rates	Change		
1978	73.8	−0.8	954,001	0.9
1979	74.5	1.0	959,269	.6
1980	75.9	1.9	970,456	1.2
1981	75.8	−.1	986,917	1.7
1982	74.6	−1.6	997,720	1.1
1983	72.2	−3.2	1,003,658	.6
1984	66.6	−7.8	992,616	−1.1
1985	63.6	−4.5	974,559	−1.8
1986	63.4	−.3	963,133	−1.2
1987	64.1	1.1	954,458	−.9
1988	64.5	.6	942,306	−1.3
1989	65.2	.6	930,994	−1.3
1990[1]	64.8	−.5	922,022	−.9
Annual average:				
1978–83	74.5	−.5	978,670	1.0
1984–90	64.6	−1.6	954,167	−1.2

[1] Estimate based on January through November 1990 compared with January through November 1989.

Source: American Hospital Association National Hospital Panel Survey.

EXPENDITURES FOR PHYSICIANS' SERVICES

Personal health care expenditures for physicians' services were $117.6 billion in 1989, an increase of 11.9 percent from the previous year (see table 12). In 1989, 22.2 percent of personal health care expenditures and 19.5 percent of all national health expenditures were for physicians' services (see table 1). Physicians, however, affect personal health care expenditures more than this might indicate. Physicians have considerable discretion in determining the volume of all medical services. It is estimated that physicians' decisions (such as ordering hospitalizations, drugs, laboratory tests) directly influence over 70 percent of all health care spending.

Third-party (public expenditures and private insurance) payments financed a large majority of physicians' services. In 1989, private health insurance paid $56.1 billion (47.6 percent) for such services. The remainder was split between direct patient payments and public expenditures. Patients or their families paid $22.4 billion (19 percent) for physicians' services. Public programs paid $39.2 billion (33.3 percent) for such services, of which $27.5 billion (23.4 percent) was composed of Federal Medicare payments (see table 12).

Inflation was a major cause of growth in spending for physicians' services. Physicians' fees have risen more rapidly (7.1 percent in 1990) than prices in the economy as a whole (5.4 percent) as measured by the Consumer Price Index (CPI) (see table 13).

An analysis done by the Health Care Financing Administration found that expenditures for physicians' services over a 10-year span increased from $21.2 billion in 1974 to $75.4 billion in 1984, an annual growth rate of about 13.5 percent. Of this 10-year expenditure growth, increases in overall inflation accounted for 52.8 percent, increases in the medical care price increases in excess of general price inflation accounted for 19.7 percent, and increased intensity per visit for 27.5 percent. A change in the number of visits per person had the effect of decreasing the growth in physician expenditures by 7.5 percent.

According to the Health Care Financing Administration, if the change in physician expenditures is examined just for the period 1985–1986, the factors accounting for the growth look very different. Increases in overall inflation accounted for 25.3 percent, increases in medical care prices in excess of general inflation accounted for 41.1 percent, and increased intensity per visit accounted for 22.4 percent. A change in the number of visits per person had the effect of increasing the growth in physician expenditures by 2.8 percent, while changes in the population accounted for 8.4 percent.

The average 1988 net income after expenses but before taxes for physicians was $144,700, a 9.4 percent increase over the previous year (see table 14). Anesthesiologists experienced the highest growth in average net income, 19 percent. In contrast, the net income of radiologists rose by 2.2 percent. Surgeons led all specialty groups with an average net income of $207,500. By region, average net income growth rates varied greatly, ranging from 0.6 percent in the Pacific region to 20.3 percent in New England. Physicians in the East South Central and West South Central regions had the highest average net incomes ($165,000 and $160,900 respectively). Physicians in the Mountain region had the lowest average net income, $132,100. The growth rates differed in rural and urban areas, ranging from 2.5 percent in nonmetropolitan areas and 9.8 percent in metropolitan areas with less than 1 million population to 10.0 percent in metropolitan areas with more than 1 million population. The average net income of self-employed physicians ($160,000) continued to be higher than that of employee physicians ($113,000), although the latter group showed a faster rate of income growth.

Table 15 shows average physician net incomes in nominal and real dollars, where real income is expressed in 1988 dollars. Physicians' average net income increased about 140 percent between 1977 and 1988. However, average real incomes (adjusted for inflation) increased about 22 percent, or at an annualized rate of 1.8 percent.

Table 16 shows physicians' average net incomes by specialty. From 1981 to 1988, nominal net income increased in all specialties.

Table 17 shows the distribution of physicians' net income in 1988 for all physicians and for selected specialties. While the average income of all physicians was $144,700, half of all physicians earned less than $120,000. One-fourth of all physicians earned less than $80,000, whereas one-fourth earned more than $180,000. Average net income was higher than median income for all specialties. Anesthesiologists and surgeons had the highest median incomes, with half earning more than $180,000.[1]

The continuing survey of physicians' income conducted by Medical Economics showed that the typical office-based physician received 77 percent of his 1986 gross practice income from third parties (see table 18). This is up from about 67 percent as reported in the 1981 survey. On the average, 20 percent came from commercial insurers, 17 percent from Blue Shield, 24 percent from Medicare, 7 percent from Medicaid, 7 percent from health maintenance organizations (HMOs) and independent practice associations (IPAs), and 2 percent from preferred provider organizations (PPOs). As table 18 shows the importance of each source of payment varied by specialty, with thoracic surgeons, on average, receiving the highest percent of gross pay from Medicare (43 percent), while pediatricians on average only received about 2 percent of their gross income from Medicare. Comparing the 1986 survey results with those from 1981, Medicare has increased in importance (rising from 17 to 24 percent) for all physicians, while commercial plans, Blue Shield and Medicaid have declined in importance. Commercial plans dropped from 21 to 20 percent, Blue Shield declined from 20 to 17 percent, and Medicaid dropped from 8 to 7 percent. Emerging as an important source of payment are HMOs, IPAs, and PPOs, accounting for a total of 9 percent of physicians' gross wages in 1986. PPOs were not a factor in 1981, representing on average less than 1 percent of all physicians' gross income, while HMOs and IPAs increased from 3 to 7 percent.

---

[1] Gonzalez, Martin L. and David W. Emmons, eds. Socioeconomic Characteristics of Medical Practice, 1989. Chicago, AMA Center for Health Policy Research, pp. 18–19.

TABLE 12.—EXPENDITURES FOR PHYSICIAN SERVICES [1] BY SOURCE OF FUNDS, 1980, AND 1985–89

	1980		1985		1986		1987		1988		1989	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	41,867	100.0	73,955	100.0	82,050	100.0	92,986	100.0	105,130	100.0	117,648	100.0
Out of pocket	11,262	26.9	16,103	21.8	16,321	19.9	17,844	19.2	20,107	19.1	22,378	19.0
Third party	30,584	73.1	57,820	78.2	65,697	80.1	75,106	80.8	84,983	80.8	95,226	80.9
Private health insurance	17,957	42.9	33,708	45.6	38,332	46.7	43,841	47.1	50,085	47.6	56,051	47.6
Other private funds	23	.1	32	0	33	0	36	0	40	0	44	0
Government	12,627	30.2	24,112	32.6	27,365	33.4	31,265	33.6	34,898	33.2	39,175	33.3
Federal	9,668	23.1	19,202	26.0	21,830	26.6	24,949	26.8	28,069	26.7	31,784	27.0
Medicare [2]	7,948	19.0	16,616	22.5	18,849	23.0	21,551	23.2	24,211	23.0	27,480	23.4
Medicaid [3]	1,179	2.8	1,613	2.2	1,829	2.2	2,003	2.2	2,204	2.1	2,603	2.2
Other Federal	540	1.3	974	1.3	1,151	1.4	1,395	1.5	1,654	1.6	1,702	1.4
State and local	2,959	7.1	4,910	6.6	5,535	6.7	6,316	6.8	6,829	6.5	7,391	6.3
Medicaid [4]	954	2.3	1,235	1.7	1,339	1.6	1,537	1.7	1,541	1.5	1,631	1.4
Other State and local	2,004	4.8	3,675	5.0	4,196	5.1	4,780	5.1	5,289	5.0	5,761	4.9

---

[1] Encompasses the cost of all services and supplies provided in physicians' offices, the cost for services of private practitioners in hospitals and other institutions, and the cost of diagnostic work performed in independent clinical laboratories. The salaries of staff physicians are counted with expenditures for the services of the employing institution.

[2] Represents total expenditures for benefits. Net Federal outlays are lower, because expenditures are partially offset by beneficiary premuims.

[3] Federal share only.

[4] State share only.

Source: Health Care Financing Administration: Office of the Actuary: Data from the Office of National Cost Estimates.

TABLE 13.—ANNUALIZED RATES OF CHANGE IN THE CONSUMER PRICE INDEX (CPI–U),[1] 1965–90

	CPI all items	CPI, all items less medical care	Medical care total	Physicians' services
1965	1.7	1.5	2.5	3.6
1966	2.9	3.0	4.4	5.8
1967	2.9	2.4	7.1	7.1
1968	4.2	4.1	6.1	5.6
1969	5.4	5.4	6.9	6.9
1970	5.9	5.8	6.3	7.5
1971	4.3	4.1	6.5	6.9
1972	3.3	3.3	3.2	3.1
1973	6.2	6.4	3.9	3.3
1974	11.0	11.1	9.3	9.2
1975	9.1	8.9	12.0	12.3
1976	5.8	5.5	9.5	11.3
1977	6.5	6.2	9.6	9.3
1978	7.7	7.6	8.4	8.3
1979	11.3	11.4	9.3	9.2
1980	13.5	13.6	10.9	10.6
1981	10.4	10.3	10.8	11.0
1982	6.1	5.9	11.6	9.4
1983	3.2	2.9	8.7	7.7
1984	4.3	4.1	6.2	7.0
1985	3.8	3.6	6.7	6.9
1986	1.9	1.5	7.5	7.2
1987	3.7	3.5	6.6	7.3
1988	4.1	3.9	6.5	7.2
1989	4.8	4.6	7.7	7.4
1990	5.4	5.2	9.0	7.1

---

[1] CPI index for all urban consumers, unadjusted figures.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index.

TABLE 14.—PHYSICIANS' AVERAGE NET INCOME AFTER EXPENSES BUT BEFORE TAXES, SURVEY RESULTS, 1983–88

	Average net income [1] (in thousands of dollars)						Percent change 1987–88
	1983	1984	1985	1986	1987	1988	
All physicians [2]	104.1	108.4	112.2	119.5	132.3	144.7	9.4
Specialty:							
General/family practice	68.5	71.1	77.9	80.3	91.5	94.6	3.4
Internal medicine	93.3	103.2	101.0	109.4	121.8	130.9	7.5
Surgery	145.5	151.8	155.4	162.4	187.9	207.5	10.4
Pediatrics	70.7	74.5	77.1	81.8	85.3	94.9	11.3
Obstetrics/gynecology	119.9	116.2	122.7	135.9	163.2	180.7	10.7
Radiology	148.0	139.8	150.8	168.8	180.7	184.6	2.2
Psychiatry	80.0	85.5	88.6	91.5	102.7	111.4	8.5
Anesthesiology	144.7	145.4	140.2	150.2	163.1	194.5	19.3
Census Division:							
New England	84.5	87.3	108.3	107.1	110.6	133.0	20.3
Middle Atlantic	98.6	98.4	107.9	114.6	126.1	134.9	7.0
East North Central	114.3	109.4	118.9	126.6	137.6	147.0	6.8
West North Central	110.5	110.7	113.7	120.7	133.9	138.2	3.2
South Atlantic	106.7	114.5	112.6	119.6	133.8	156.0	16.6
East South Central	114.9	122.2	115.0	122.6	141.2	165.0	16.9
West South Central	124.4	119.1	123.3	129.0	140.4	160.9	14.6
Mountain	91.4	102.3	97.5	108.5	125.5	132.1	5.3
Pacific	103.1	109.4	113.6	119.0	135.4	136.2	.6
Location:							
Nonmetropolitan	87.2	90.9	94.2	107.7	117.9	120.9	2.5
Metropolitan:							
Less than 1,000,000	111.0	115.1	118.1	124.5	140.4	154.1	9.8
1,000,000 and over	106.3	106.4	112.8	117.5	127.9	140.7	10.0
Employment Status:							
Self-employed	115.9	118.6	124.5	131.1	146.2	160.0	9.4
Employee	77.6	80.4	83.8	91.7	99.6	113.0	13.5

---

[1] Average net income after expenses but before taxes. These figures include contributions made into pension, profit-sharing, and deferred compensation plans.

[2] Includes physicians in specialties not reported separately.

Source: Socioeconomic Characteristics of Medical Practice, 1987 and 1988, American Medical Association.

TABLE 15.—AVERAGE PHYSICIAN NET INCOME AFTER EXPENSES, BEFORE TAXES, 1977–88

[Dollars in thousands]

	Nominal	Real (1988)
1977	$60.4	$118.3
1978	64.6	117.5
1979	77.4	126.5
1980	NA	NA
1981	89.9	117.2
1982	97.7	120.1
1983	104.1	124.0
1984	108.4	123.8
1985	112.2	123.4
1986	119.5	129.0
1987	132.3	137.7
1988	144.7	144.7

NA: Not available.

Note: No data for 1980. Real (1988 dollars) incomes are calculated using the consumer price index for all urban consumers.

Source: CRS analysis of data from: Gonzales, Martin L., and David W. Emmons, eds., "Socioeconomic Characteristics of Medical Practice, 1989," Chicago, AMA Center for Health Policy Research, 1989, p. 124.

TABLE 16.—CHANGES IN PHYSICIAN NET INCOME AFTER EXPENSES, BEFORE TAXES, 1981–88

[Dollars in thousands]

	Median net income			Average annual percent change	
	1981	1988 nominal	1988 (1981 dollars) [1]	Nominal	Real
All physicians [2]	$75	$120	$92	6.9	3.0
Specialty:					
General/family practice	60	85	65	5.1	1.2
Internal medicine	72	109	84	6.1	2.2
Surgery	100	180	138	8.8	4.7
Pediatrics	55	85	65	6.4	2.5
Obstetrics/gynecology	96	150	115	6.6	2.6
Radiology	105	158	121	6.0	2.1
Psychiatry	64	97	75	6.1	2.2
Anesthesiology	105	180	138	8.0	4.0
Pathology	75	130	100	8.2	4.2
Census Division:					
New England	65	110	85	7.8	3.8
Middle Atlantic	70	110	85	6.7	2.7
East North Central	80	120	92	6.0	2.0
West North Central	80	120	92	6.0	2.0
South Atlantic	77	125	96	7.2	3.2
East South Central	80	132	101	7.4	3.4
West South Central	80	130	100	7.2	3.2
Mountain	74	110	85	5.8	1.9
Pacific	77	115	88	5.9	2.0

---

[1] In 1981 dollars using the consumer price index for all urban consumers.

[2] Includes physicians in specialties not listed separately.

Source: Gonzalez, Martin L., and David W. Emmons, eds. "Socioeconomic Characteristics of Medical Practice, 1989," Chicago, AMA Center for Health Policy Research, 1989, p. 18.

TABLE 17.—DISTRIBUTION OF PHYSICIAN NET INCOME AFTER EXPENSES, BEFORE TAXES, BY SPECIALTY AND CENSUS DIVISION, 1988

[In thousands of dollars]

	25th Percentile	50th Percentile	75th Percentile	Mean
All physicians [1]	80	120	180	144.7
Specialty:				
General/family practice	60	85	114	94.6
Internal medicine	77	109	156	130.9
Surgery	117	180	260	207.5
Pediatrics	60	85	120	94.9
Obstetrics/gynecology	100	150	230	180.7
Radiology	110	158	230	184.6
Psychiatry	74	97	130	111.4
Anesthesiology	126	180	250	194.5
Pathology	85	130	153	131.0
Census division:				
New England	80	110	155	133.0
Middle Atlantic	76	110	160	134.9
East North Central	80	120	180	147.0
West North Central	78	120	166	138.2
South Atlantic	87	125	200	156.0
East South Central	85	132	213	165.0
West South Central	83	130	210	160.9
Mountain	70	110	175	132.1
Pacific	80	115	168	136.2

[1] Includes physicians in specialties not listed separately.

Source: Gonzalez, Martin L., and David W. Emmons, eds. "Socioeconomic Characteristics of Medical Practice, 1989." Chicago, AMA Center for Health Policy Research, 1989, p. 19.

TABLE 18.—THIRD PARTY SOURCES OF PHYSICIAN PAYMENT FOR SELECTED SPECIALTIES, 1986

Specialty	Commercial plans		Blue Shield		Medicare		Medicaid		HMOs/IPAs		PPOs	
	Average annual payment	As percent of gross practice income	Average annual payment	As percent of gross practice income	Average annual payment	As percent of gross practice income	Average annual payment	As percent of gross practice income	Average annual payment	As percent of gross practice income	Average annual payment	As percent of gross practice income
Family practice	23,990	17	17,770	13	27,690	21	10,170	8	11,510	9	2,910	2
General practice	16,560	15	13,350	15	23,090	22	10,550	10	6,760	6	1,940	2
General surgeons	41,700	21	37,900	21	60,770	33	14,460	9	10,880	5	3,230	2
Pediatricians	21,360	15	15,860	12	1,620	2	13,270	11	13,000	9	4,330	3
Plastic surgeons	71,880	26	46,640	17	27,610	10	8,800	4	11,490	4	7,400	2
Psychiatrists	29,260	21	20,420	17	8,280	8	6,440	6	6,700	5	3,630	3
Internists	22,550	15	21,680	15	49,780	37	7,100	6	8,390	7	2,270	2
Neurosurgeons	95,440	33	51,800	21	57,440	22	16,130	7	13,270	5	5,250	2
OBG specialists	70,730	32	47,780	23	8,670	4	15,150	9	17,320	9	10,030	4
Opthalmologists	23,830	10	30,670	12	123,730	42	10,590	5	10,470	5	4,780	2
Orthopedists	82,650	29	56,690	20	62,990	23	14,010	6	13,920	5	5,440	2
Radiologists	33,290	18	37,440	22	51,270	29	15,080	10	12,220	7	4,000	2
Thoracic surgeons	43,460	18	50,560	21	98,640	43	16,570	7	11,110	5	3,080	1
All surgical specialists	55,400	24	43,340	19	58,000	25	13,390	7	12,970	6	6,350	3
All non-surgical specialists	28,970	18	24,870	17	38,990	24	9,730	7	10,210	7	3,790	2
All M.D.s	37,270	20	29,740	17	43,220	24	11,160	7	10,980	7	4,500	2

Source: Paxton, Harry T. "How Much Cheer Do Third Parties Bring You?" Medical Economics, Dec. 21, 1987, pp. 118–119.

SUPPLY OF HOSPITAL BEDS AND PHYSICIANS

The national supply of community hospital beds per 1,000 population steadily increased from the 1940's, reaching a peak of 4.6 beds per 1,000 population in 1975. By 1987, the number of beds had dropped to 4.0 per 1,000 population. Similar trends can be seen in the nine census regions, except for New England, which has seen a reduction since 1940 from 4.4 beds to 3.6 beds per 1,000 population in 1987, and the Pacific region, where the reduction has been from 4.1 beds in 1940 to 3.0 beds in 1987. The area experiencing the largest increase has been the East South Central, where beds increased from 1.7 per 1,000 population in 1940 to 5.1 in 1980, falling back to 4.9 in 1987. (see table 19).

TABLE 19.—HOSPITAL BEDS PER 1,000 POPULATION,[1] ACCORDING TO GEOGRAPHIC DIVISION: UNITED STATES, SELECTED YEARS 1940–87

[Data are based on reporting by facilities]

Geographic division	Year							
	1940 [2]	1950 [2]	1960 [3]	1970	1975	1980	1986	1987
United States	3.2	3.3	3.6	4.3	4.6	4.5	4.1	4.0
New England	4.4	4.2	3.9	4.1	4.2	4.1	3.8	3.6
Middle Atlantic	3.9	3.8	4.0	4.4	4.6	4.6	4.3	4.2
East North Central	3.2	3.2	3.6	4.4	4.7	4.7	4.3	4.2
West North Central	3.1	3.7	4.3	5.7	5.8	5.8	5.3	5.2
South Atlantic	2.5	2.8	3.3	4.0	4.3	4.5	4.0	3.9
East South Central	1.7	2.1	3.0	4.4	4.9	5.1	5.0	4.9
West South Central	2.1	2.7	3.3	4.3	4.7	4.7	4.0	4.0
Mountain	3.6	3.8	3.5	4.3	4.0	3.8	3.4	3.3
Pacific	4.1	3.2	3.1	3.7	3.9	3.5	3.1	3.0

[1] Civilian population.

[2] 1940 and 1950 data are estimated based on published figures.

[3] 1960 includes hospital units of institutions.

Note: Hospitals include all non-Federal short-stay hospitals classified by the American Hospital Association according to one of the following services: general medical and surgical; obstetrics and gynecology; eye, ear, nose, and throat, rehabilitation; orthopedic; other specialty; children's general; children's eye, ear, nose, and throat; children's rehabilitation; children's orthopedic; and children's other specialty.

Source: Health, United States, 1989. U.S. Department of Health and Human Services. DHHS Publication No. (PHS) 90–1232, Table 96, pp. 218–219.

The number of active physicians in the country has increased from 279,212 in 1970 to 554,155 in 1988. This growth rate exceeded the rate at which the population of the Nation grew during the decade.

As table 20 below indicates, the ratio of physicians-to-population increased from 137 physicians per 100,000 population in 1970 to 229 physicians per 100,000 population in 1988. This table also indicates variations in the supply of physicians relative to population by State. In 1988, the District of Columbia had the highest ratio (629 physicians per 100,000 population) while Mississippi had the lowest ratio (135 physicians per 100,000 population).

TABLE 20.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilian population]

Geographic area	1970	1975 [1]	1988	1989 [2]	1989 rank
United States [3]	137	156	229	234	....
Alabama	84	100	162	167	43
Alaska	65	92	145	151	49
Arizona	123	151	227	230	15
Arkansas	85	95	157	161	46
California	175	196	269	272	7
Colorado	163	172	221	228	16
Connecticut	178	207	317	325	5
Delaware	124	138	210	213	21
District of Columbia	365	436	629	637	1
Florida	124	155	244	248	12
Georgia	100	119	178	183	34
Hawaii	138	160	253	259	10
Idaho	87	95	136	139	51
Illinois	130	156	224	228	18
Indiana	96	109	163	167	42
Iowa	97	105	157	163	45
Kansas	108	128	186	192	32
Kentucky	96	117	172	177	38
Louisiana	114	127	194	198	29
Maine	98	122	201	208	23
Maryland	171	206	349	356	3
Massachusetts	194	222	346	357	2
Michigan	117	135	195	198	30
Minnesota	142	162	232	236	14
Mississippi	78	87	135	139	50
Missouri	120	141	202	206	24
Montana	97	111	168	176	39
Nebraska	106	124	179	183	35
Nevada	102	117	173	174	41
New Hampshire	125	146	213	221	20
New Jersey	136	162	253	260	9
New Mexico	103	121	193	200	28
New York	223	235	331	335	4
North Carolina	103	124	195	202	26
North Dakota	88	104	179	181	36
Ohio	125	137	206	209	22
Oklahoma	94	108	156	163	44
Oregon	133	160	222	228	17
Pennsylvania	143	158	246	251	11
Rhode Island	143	175	265	272	8

TABLE 20.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE—Continued

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilian population]

Geographic area	1970	1975 [1]	1988	1989 [2]	1989 rank
South Carolina	85	106	170	174	40
South Dakota	76	83	151	154	48
Tennessee	113	134	199	204	25
Texas	109	129	180	185	33
Utah	129	150	191	196	31
Vermont	169	189	275	285	6
Virginia	113	136	222	228	19
Washington	136	154	233	238	13
West Virginia	98	120	179	181	37
Wisconsin	113	129	197	202	27
Wyoming	91	100	147	155	47

[1] Numbers of active non-Federal physicians are adjusted for 1975 to include about 90 percent of those not classified as to status or activity by the American Medical Association.

[2] Physician numbers as of January 1, 1989; Civilian population as of July 1, 1988.

[3] Excludes counts of physicians in U.S. possessions and with unknown addresses.

Source: American Medical Association, Physician Characteristics and Distribution in the United States 1988 edition. Table A-9. (In press.)

The number of physicians in the United States is expected to continue to grow at a faster rate than the general population. The Department of Health and Human Services estimated that there were 221 active physicians per 100,000 population in 1985. They project ratios of 238 in 1990, 252 in 1995, and 264 in 2000.

HEALTH INSURANCE COVERAGE

HEALTH INSURANCE STATUS IN 1989

Most people have some form of health insurance. In 1989, an estimated 86.4 percent of the total noninstitutionalized population had public or private coverage during at least part of the year. However, an estimated 33.4 million Americans, or 13.6 percent of the population, were without health insurance in 1989. All but 0.3 million of the uninsured were under age 65; consequently 15.0 percent of the nonelderly population were uninsured.

These estimates are based on an analysis of the March 1990 Current Population Survey (CPS), a household survey conducted by the Census Bureau of the Department of Commerce. Each year's March CPS asks whether persons had coverage from selected sources of health insurance at any time during the preceding calendar year. Thus the March 1990 CPS reflects respondents' recollections of coverage during all of 1989.[2]

---

[2] Some analysts have suggested that respondents may actually be reporting their coverage status at the time of the survey, rather than for the previous year.

The questionnaires used in March 1988–1990 differed from those used in previous years. In addition to the standard series of questions about sources of health insurance coverage, a separate part of the survey included further health insurance questions. Some respondents reported that they had no health insurance in one part of the questionnaire and reported that they had coverage in another part. Different analyses of the CPS data have used different assumptions in reconciling these discrepancies and other potential sources of error in the survey responses.

CHARACTERISTICS OF THE UNINSURED

Some segments of the population are more likely to have health insurance coverage than others, and different groups rely to a different extent on private insurance coverage and on public programs such as Medicare and Medicaid. Tables 21–23 divide the population according to age and income and show the sources of coverage for each group.[3] (The total noninstitutionalized population in 1989 was 246.1 million.)

TABLE 21.—PERCENT OF U.S. NONINSTITUTIONALIZED POPULATION OBTAINING HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES, BY AGE, 1989

	Own job	Family member's job	Medicare	Medicaid	Other [1]	Uninsured
Age:						
Under 18	([2])	71.4	([2])	12.6	2.6	13.3
18 to 24	25.4	25.5	0.7	6.7	16.6	25.1
25 to 34	50.8	15.9	0.8	5.3	8.9	18.3
35 to 44	54.1	20.1	1.4	3.3	8.7	12.5
45 to 54	52.4	20.0	2.3	3.0	10.0	12.4
55 to 64	44.5	17.9	7.4	3.5	15.1	11.6
65 and over	2.3	.5	95.6	([2])	.6	1.0
Total	29.2	30.7	12.8	6.0	7.7	13.6

[1] "Other" includes private non-group coverage, CHAMPUS; and miscellaneous other sources.
[2] 0.1 percent or less.

Source: CRS analysis of data from the March 1990 Current Population Survey.

As Table 21 shows, the rate of insurance coverage is lowest among young adults. Over 25 percent of persons aged 18 to 24 were without coverage in 1989. Over the next several age groups, coverage rates increase, chiefly because older workers are more likely to obtain insurance through their own employment. Finally, the availability of Medicare to most individuals aged 65 and over meant that 1 percent of this group was uninsured.

---

[3] About 14 percent of the population reported more than one source of coverage during the year. The dual coverages may have been either consecutive or simultaneous. For the purpose of these tables, each individual has been assigned to one primary source of coverage according to the following hierarchy: Medicare, own job, other's job, Medicaid, other. Thus someone reporting coverage through her own work and also through Medicaid would be assigned to the "own job" category. This assignment does not necessarily reflect actual primary and secondary liability.

Table 22 shows the percentage of the total uninsured population of each age group. Of the 33.4 million uninsured, 25.6 percent are children. Young adults (ages 18 to 24) total 19.0 percent and persons 25 to 34 total 23.7 percent of the uninsured.

TABLE 22.—U.S. NONINSTITUTIONALIZED POPULATION WITHOUT HEALTH INSURANCE, BY AGE, 1989

Age	Percent of the uninsured
Under 18	25.6
18 to 24	19.0
25 to 34	23.7
35 to 44	13.9
45 to 54	9.4
55 to 64	7.4
65 and over	.9
Total	[1] 99.9

[1] Percentages do not add to 100 because of rounding.

Source: CRS analysis of March 1990 Current Population Survey.

Table 23 shows coverage rates by family income, expressed as a percentage of the Federal poverty income level. Those in the lowest income groups are least likely to have coverage; those who do have coverage are most likely to rely on Medicaid or on the sources of insurance classed as "other." (These include non-employer based private coverage, CHAMPUS, and State and local indigent care programs, and miscellaneous other sources of coverage.) As family income rises, both overall coverage rates and the degree of reliance on employer coverage increase.

TABLE 23.—PERCENT OF U.S. NONINSTITUTIONALIZED POPULATION OBTAINING HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES BY FAMILY INCOME, 1989

Income as percent of poverty	Own job	Family member's job	Medicare	Medicaid	Other	[1] Uninsured
Under 50	2.7	9.9	5.1	34.1	9.9	38.2
50 to 99	6.2	12.0	21.2	26.3	7.5	26.8
100 to 149	13.0	21.6	23.9	6.7	9.3	25.5
150 to 199	21.4	29.6	18.4	2.4	9.1	19.1
200 to 249	28.0	34.4	14.1	1.2	8.7	13.6
250 and over	41.0	37.8	9.3	0.2	6.6	5.0
Total	29.2	30.7	12.8	6.0	7.7	13.6

[1] "Other" includes private nongroup coverage, CHAMPUS, and miscellaneous other sources.

Source: CRS analysis of data from the March 1990 Current Population Survey.

Table 24 combines age and income and shows the percent of persons in each age/income group without health insurance. Overall, the trends shown in this table are similar to those in the previous tables: the rate of uninsurance drops with increasing age and income. There are some exceptions, however. In the very lowest income group, those with incomes below 50 percent of the poverty level, those aged 25 to 54, are least likely to have coverage. This may reflect the categorical limitations on Medicaid coverage, which exclude single adults and childless couples who are not aged or disabled.

TABLE 24.—PERCENT OF THE U.S. NONINSTITUTIONALIZED POPULATION WITHOUT HEALTH INSURANCE, BY AGE AND INCOME, 1989

Income as a percent of poverty level	Under 18	18 to 24	25 to 341	35 to 44	45 to 54	55 to 64	65 and over
Under 50	26.2	45.5	51.6	53.3	55.4	46.9	16.6
50 to 99	25.3	40.9	37.5	35.4	36.2	28.4	.7
100 to 149	26.0	39.0	38.1	35.0	35.4	26.7	.9
150 to 199	17.0	32.7	27.5	22.1	27.2	16.9	.2
200 to 249	11.6	24.7	16.8	15.0	17.3	14.6	.5
250 and over	3.8	10.5	7.0	4.6	5.0	4.1	.5

Source: CRS analysis of data from the March 1990 Current Population Survey.

FACTORS IN EMPLOYMENT-BASED COVERAGE

In the United States, health insurance offered on a job is the single most important source of coverage. Employer plans covered 147.7 million Americans in 1989, or 60 percent of the population. If only the nonaged are considered, this figure rises to over two-thirds. Persons covered under employer plans are almost equally divided between those obtaining coverage through their own work (72 million) and those obtaining coverage as dependents on another family member's policy (75.7 million).

In 1989, 132.7 million people worked at least part of the time. Of these, 70 million (53 percent) obtained coverage through their own work, while 23 million (18 percent) were covered through another family member's employment. Another 20.3 million workers (15.3 percent) were covered by Medicare, Medicaid, CHAMPUS, or individual private coverage. This left 19.4 million workers, or about 14.6 percent, without health insurance coverage.[4]

One important factor in employment-based coverage is the degree of attachment to the labor force. Employers who provide coverage to their full-time workers may not offer that coverage to part-time employees. Workers in seasonal industries, who are employed only part of the year, are also less likely to be covered. Table 25 shows the workforce attachment of the population without health insurance coverage in 1989. Half the uninsured, 16.8 million, worked only part time or part of the year, or were dependents of part time or part year workers, while another 14.9 percent had no work force attachment. However, 34.7 percent of the uninsured, nearly 11.6 million persons, were full year, full time workers or the dependents of such workers. All told, 28.4 million uninsured persons had at least some ties to the workforce.

---

[4] The CPS data do not differentiate between workers who were in jobs where employers did not offer health insurance and workers who declined health insurance offered by an employer.

TABLE 25.—PERSONS WITHOUT HEALTH INSURANCE BY ATTACHMENT TO THE WORKFORCE, 1989

[Thousands]

	Workers	Dependent	Total	Percent of uninsured
Nonworker	[1] 3,738	1,237	4,975	14.9
Full year/full time worker	7,315	4,258	11,573	34.7
Full year/part time worker	1,720	1,085	2,805	8.4
Part year/full time worker	5,667	3,428	9,095	27.2
Part year/part time worker	3,065	1,872	4,937	14.8
Total	21,505	11,880	33,385	100.0

[1] Heads of household in families with no workforce attachment.

Source: CRS analysis of data from the March 1990 Current Population Survey. Full year workers were employed 50 or more weeks during the year. Full time workers worked an average of 35 or more hours per week during the weeks they were employed.

The likelihood that workers will obtain coverage through their jobs is largely tied to two characteristics of employers: the size of the firm and the type of industry. Tables 26 and 27 show insurance coverage in 1989 for workers classed according to these two characteristics of their employers. As table 26 indicates, workers in the smallest firms were least likely to obtain employer-based coverage and most likely to be uninsured.

TABLE 26.—PERCENT OF WORKERS OBTAINING HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES, BY SIZE OF EMPLOYER, 1989

Firm size	Own job	Family member's job	Medicare	Medicaid	Other [1]	Uninsured
Under 25	26.5	23.7	6.1	2.3	17.7	23.8
25 to 99	51.9	18.2	3.3	2.2	7.5	16.8
100 to 499	62.2	14.9	2.7	1.9	6.1	12.3
500 to 999	66.7	14.9	2.0	1.4	6.2	8.8
1,000 and over	67.2	13.5	1.9	1.5	8.0	7.9
Unemployed or not in labor force	[2] 1.9	46.5	23.9	10.9	4.3	12.4
Total	29.2	30.7	12.8	6.0	7.7	13.6

[1] Includes private non-group coverage, CHAMPUS, and miscellaneous other sources.

[2] Persons reporting coverage through their own employment and also reporting that they did not work during the year. These include retirees, as well as some persons who responded inaccurately to one of the questions.

Source: CRS analysis of data from the March 1990 Current Population Survey. Firm size is that of the firm employing the worker for the longest period during the year.

Table 27 shows insurance coverage for workers by industry class. The industries showing the lowest rates of job-based coverage are those where employment is seasonal (as in agriculture or construction) and those that tend to use low-wage workers and/or part time workers (as in personal services, entertainment, and retail trade). Employer-provided health insurance is most common in industries with a stable work force, such as government, and those whose workers are generally in collective bargaining arrangements, such as manufacturing, transportation, and mining.

TABLE 27.—PERCENT OF WORKERS OBTAINING HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES, BY MAJOR INDUSTRY CLASS, 1989

Industry class	Own job	Family member's job	Medicare	Medicaid	Other [1]	Uninsured
Agriculture, forestry and fisheries	17.8	18.6	8.6	2.8	24.0	28.2
Personal services, including household	22.7	26.4	6.7	4.0	15.7	24.5
Entertainment and recreation services	29.0	27.9	5.5	1.7	14.2	21.6
Retail trade	31.8	27.7	3.3	3.1	13.8	20.3
Business and repair services	41.0	18.6	4.3	2.6	12.1	21.5
Construction	43.9	13.6	2.6	1.7	10.9	27.3
Professional and related services	55.6	20.3	4.2	1.7	9.5	8.7
Finance, insurance, and real estate	61.8	16.4	3.3	0.8	9.3	8.5
Wholesale trade	60.3	13.2	3.8	1.2	8.5	13.2
Manufacturing, nondurable goods	68.8	10.6	2.2	1.8	4.2	12.4
Public administration	73.9	9.5	3.1	1.0	7.6	5.0
Mining	76.0	5.3	2.6	0.5	5.7	9.9
Transportation, communications, and utilities	73.5	8.9	1.7	0.8	5.2	9.9
Manufacturing, durable goods	77.1	7.8	1.7	0.8	3.9	8.7

---

[1] Includes private non-group coverage, CHAMPUS, and miscellaneous other sources.

Source: CRS analysis of data from the March 1990 Current Population Survey. Industry is that in which the worker was employed the longest during the year.

TRENDS IN HEALTH INSURANCE COVERAGE

Between 1979 and 1986, the percent of the nonaged population who were uninsured increased from 14.6 percent to 17.5 percent. The number of uninsured would have been expected to grow from 28.4 to 30.8 million simply because the overall nonaged population grew. However, the number of nonaged uninsured actually grew from 28.4 million to 36.8 million. That is, the number of uninsured increased by 8.4 million people, yet only 2.4 million or 29 percent of the growth was due to an expanding nonaged population.

Table 28 shows trends in the nonaged uninsured for selected years from 1979 to 1986. Most of the change in health insurance coverage occurred between 1979 and 1984; after 1984, coverage rates remained fairly constant. (As was discussed above, data for years after 1986 are not comparable to those for earlier years.)

TABLE 28.—NUMBER AND PERCENT OF THE NONAGED POPULATION WITHOUT HEALTH INSURANCE, 1979 AND 1983–86

	1979	1983	1984	1985	1986
Number uninsured (millions)	28.4	34.8	36.8	36.7	36.8
Percent uninsured (percent)	14.6	16.9	17.7	17.6	17.5

Source: Table prepared by CRS based on data from the March 1980, March 1984, March 1985, March 1986, and March 1987 CPS. Information from 1980 to 1982 is not presented due to errors on the CPS computer tapes for those years.

To examine why the uninsured have increased since 1979, table 29 displays insurance coverage by source and year.

TABLE 29.—SOURCES OF HEALTH INSURANCE COVERAGE BY YEAR FOR NONAGED POPULATION, 1979 AND 1983–86

	Percentage of nonelderly population				
	1979	1983	1984	1985	1986
Employment-based plans:					
Covered on own job	33.1	32.5	32.6	33.1	33.4
Covered through someone else	34.3	32.1	31.4	31.2	31.4
Total employment-based	67.4	64.6	64.0	64.3	64.8
Other plans[1]	17.9	18.5	18.3	18.1	17.7
Uninsured	14.6	16.9	17.7	17.6	17.5
Total	100.0	100.0	100.0	100.0	100.0

[1] Excludes persons covered by employment-based plans.

Source: Table prepared by CRS based on data from the March 1980, March 1984, March 1985, March 1986, and March 1987 CPS. Information from 1980 to 1982 is not presented due to errors on the CPS computer tapes for those years.

The most dramatic trend shown in table 29 is the decline in the percent of the nonaged population covered by employment-based plans through another family member from 34.3 percent to 31.4 percent. This proportion declined consistently between 1979 and 1984, and then leveled off. On the other hand, the percent of the nonelderly population covered by health insurance from their own work actually increased between 1979 and 1986 from 33.1 to 33.4 percent. This percent declined during the early 1980s but increased by nearly a full percentage point between 1983 and 1986.

Several factors contributed to these changes in health insurance coverage over the 1979 to 1986 period. The first contributing factor is changes in the work force. From 1979 to 1986, the percent of the nonaged in the work force grew as the last of the "baby boomers" entered the work force. Moreover, the percent of workers in service-producing industries grew over the 8-year period. Second, demographic changes and changes in family structure contributed. The percent of the population under 18 (traditionally covered as dependents under parents' plans) has declined. Moreover, family structure has changed, with a great proportion of the nonaged population living outside of "traditional" family arrangements. Third, economic incentives contributed. Noncash compensation grew rapidly during the 1970s as high inflation and high tax rates made nontaxable, inflation-resistent noncash compensation such as health insurance more valuable relative to cash wages. The low inflation of the mid-1980s and the changed tax structure may have reduced the incentive for employees to favor compensation in noncash forms relative to cash forms. Also, the cost of family premiums has increased 66 percent in real terms over the past 10 years and the required enrollee share of premiums for family coverage has risen.

Data from the Census Bureau's CPS were used by CRS to examine the effect of the first two factors on health insurance coverage trends. However, census data are insufficient to measure the effect of economic incentives upon coverage rates. CRS found that the notion that the drop in coverage is mostly due to the movement of jobs to the service-producing sector is not supported by the CPS analysis. Decreases in coverage are found most significantly in coverage obtained through another family member's employment-based plan. The cause of the decrease in this type of coverage seems almost evenly attributable to demographic shifts and to a decline in coverage rates for spouses and children under age 18.

FACTORS LEADING TO LOSS OF COVERAGE

One of the drawbacks in using the Current Population Survey (CPS) to look at health insurance coverage is that it provides an estimate of the uninsured for a point in time, which may mask the extent to which people move in and out of coverage. Questions regarding duration of coverage and the reasons for loss of coverage cannot be adequately analyzed using the CPS.

A study based on the Census Bureau's Survey of Income and Program Participation (SIPP) for the period between June 1983 and March 1986 allows some insights into the dynamics of health insurance loss.[5] In this study, the nonaged population was divided into two groups: those respondents who had insurance in the first month of the survey, and those who did not have coverage in the first month. The results of the study permit a comparison of these two groups as they moved in and out of public and private sources of coverage through a period of 32 months. What is revealed is that the uninsured population is heterogeneous: it is made up of persons who lose coverage for short periods of time, persons who experience periodic spells without coverage, and those who are persistently uninsured for long periods of time. Moreover, when compared with all persons who lose coverage, the long-term uninsured are more likely to be poor or near poor and have less attachment or access (through family members) to employer-based health insurance coverage.

---

[5] Monheit, Alan and Claudia L. Schur. The Dynamics of Health Insurance Loss: A Tale of Two Cohorts. Inquiry. Fall, 1988, pp. 315–327. Because of differences in the survey instruments and in the methods used to analyze the survey, the SIPP and CPS estimates for the insured and uninsured population are different. For example, whereas the CRS estimate using CPS for the total nonaged uninsured population in 1984 was 36.8 million (17.7 percent), the Monheit and Schur estimate using SIPP was 30.8 million (15.5 percent).

As seen in table 30, of the 151.6 millions persons with private insurance in the first month, 78 percent experienced no transition in health insurance status over 32 months, whereas 4.8 percent experienced one transition, and 4 percent experienced more than 3 changes. Of the 30.8 million persons who were uninsured in the first month, 27.4 percent (about 8.4 million) remained uninsured throughout the 32 month period; 28.1 percent experienced one transition, whereas 12.1 percent experienced more than 3 transitions. The study also analyzed the average duration of health insurance loss, that is, spells of months without insurance and total months without insurance. It found that persons who lost private insurance during the 32 months experienced noncoverage for an average of 8.3 months. Persons who were uninsured during the first month experienced on average a total of 20.2 months without coverage (see table 31).

TABLE 30.—TRANSITIONS IN HEALTH INSURANCE STATUS OVER 32 MONTHS: NUMBER OF CHANGES AMONG PRIVATE, PUBLIC, AND NO INSURANCE COVERAGE

	Percent distribution	
	Persons with private insurance, first SIPP reference month (n=151,649,000)	Persons uninsured, first SIPP reference month (n=30,755,000)
Number of transitions:		
0	78.0	27.4
1	4.8	28.1
2	10.4	17.2
3	2.8	15.2
More than 3	4.0	12.1

Source: 1984 Panel of Survey of Income and Program Participation: NCHSR Longitudinal 32-Month File. See Monheit and Schur, 1988, p. 318, table 1.

TABLE 31.—DURATION OF HEALTH INSURANCE LOSS: TOTAL MONTHS UNINSURED

	Number (in thousands)	Average total months	Percent distribution by total months without coverage					
			1–4	5–8	9–12	13–24	25–31	32
Losers of private insurance.........	29,778	8.3	48.6	17.7	10.9	19.1	3.7	....
Uninsured cohort........................	30,755	20.2	12.2	10.5	9.6	24.3	16.1	27.4

Source: 1984 Panel of Survey of Income and Program Participation: NCHSR Longitudinal 32-Month File. See Monheit and Schur, 1988, p. 324, table 7.

The study also looked at the demographic and economic characteristics of the two groups, and revealed significant differences between the two groups (see table 32). However, of particular note are the characteristics of those who were uninsured during the entire 32 months. Of these 8.4 million people, 63.8 percent were either poor or near poor. This compares to 54.4 percent of those who were uninsured in the first month but who obtained coverage for some part of the 32 months, and 25.5 percent of those who lost private coverage after the first month. Only 31.6 percent of the persistently uninsured worked full-time, compared to 36.3 percent of the uninsured who picked up coverage, and 50.1 percent of the privately insured who lost coverage.

TABLE 32.—SELECTED CHARACTERISTICS OF THE UNINSURED: COMPARISONS OF PERSONS LOSING PRIVATE COVERAGE AFTER 1ST SIPP REFERENCE MONTH, PERSONS UNINSURED DURING 1ST SIPP REFERENCE MONTH, AND PERSONS UNINSURED THROUGHOUT PANEL

[In percent]

Characteristics [1]	Persons losing private coverage		Persons uninsured in first month (n=30,755,000)	Persons uninsured throughout (n=8,412,000)
	All persons (n=29,778,000)	Primary insured (n=11,197,000)		
Age:				
Less than 18....................	37.7	0.7	35.3	35.6
19 to 24..........................	20.6	23.9	19.9	15.7
25 to 44..........................	29.6	52.6	30.1	27.3
45 to 54..........................	6.5	11.9	6.9	10.7
55 to 64..........................	5.6	10.9	7.7	10.7
Race/ethnicity:				
White...............................	76.5	76.9	69.0	67.0
Black...............................	14.8	14.4	16.6	16.5
Hispanic...........................	6.2	5.6	10.9	14.1
Other...............................	2.5	3.1	3.5	2.4
Education: [2]				
Elementary.......................	7.2	8.2	15.1	22.9
High School......................	59.4	55.1	61.0	60.0
Some college....................	22.2	21.7	15.2	12.1
College graduate...............	11.3	15.0	8.7	5.0
Relationship to poverty level:				
Poor.................................	12.2	10.0	37.0	44.7
Near poor.........................	13.3	11.7	17.4	19.1

TABLE 32.—SELECTED CHARACTERISTICS OF THE UNINSURED: COMPARISONS OF PERSONS LOSING PRIVATE COVERAGE AFTER 1ST SIPP REFERENCE MONTH, PERSONS UNINSURED DURING 1ST SIPP REFERENCE MONTH, AND PERSONS UNINSURED THROUGHOUT PANEL—Continued

[In percent]

Characteristics [1]	Persons losing private coverage		Persons uninsured in first month (n=30,755,000)	Persons uninsured throughout (n=8,412,000)
	All persons (n=29,778,000)	Primary insured (n=11,197,000)		
Other low	14.5	13.3	13.7	12.7
Middle income	40.4	40.4	23.8	18.1
High income	19.6	24.6	8.2	5.3
Employment status: [3]				
Full time	50.1	77.9	36.3	31.6
Part time	17.5	10.2	14.9	15.7
Unemployed	8.3	4.6	18.3	15.5
Not in labor force	24.1	7.4	30.5	37.2

[1] Based on first SIPP reference month.

[2] Does not include persons who did not attend elementary school.

[3] Does not include persons 15 years of age and under.

Source: 1984 Panel of Survey of Income and Program Participation: NCHSR Longitudinal 32-Month File. See: Monheit and Schur, 1988, p. 323, table 6.

Also compared was the insurance coverage experience of persons with employment-related coverage versus those who had coverage from some other private source (such as individual subscriber policies). Thirty-three percent of the persons with non-employment-related coverage lost coverage while 17.5 percent of those persons with employment-related coverage experienced a loss of coverage, indicating that for those without access to employment-related plans, it may be more difficult to retain insurance.

A more recent study using SIPP data for the 28-month period beginning February 1985 further underscores the importance of transitions in health insurance coverage over time.[6] It found that 28 percent of the population (63 million people) experienced at least 1 month without health insurance. Some 7 percent of the total population was covered for 6 months or less, and 4 percent (about 9 million) lacked coverage for the entire 28-month period.

THE UNINSURED AND UNCOMPENSATED CARE

The increased number of people without health insurance has expanded the potential volume of hospital uncompensated care. At the same time, hospitals face pressures to cut costs for insured patients, making more difficult the absorption of costs for patients unable to pay.

Uncompensated care is a hospital accounting term used to describe care given to patients unable (or unwilling) to pay. In general, the term refers to the value of services rendered for which the hospital does not receive payment or receives only partial payment. Uncompensated care can include the cost of services for which no payment is expected (charity care) and for which payment is expected but not received (bad debt). Bad debts consist of charges not paid for by uninsured individuals and partial charges left unpaid by insured patients who decline to pay the out-of-pocket portion of their bills that arise from deductibles, coinsurance, expenses above a maximum plan payment, and services not covered by the plan.

---

[6] Nelson, Charles and Kathleen Short. "Health Insurance Coverage 1986–1988." U.S. Department of Commerce, Bureau of the Census. Current Population Reports. Series P-70, No. 17. U.S. Government Printing Office. Washington. 1990.

The American Hospital Association (AHA) estimates on the basis of survey data that hospitals' total costs for uncompensated care were $11.1 billion in 1989. (This figure excludes $284 million in costs incurred by 37 hospitals that derive the bulk of their income from tax appropriations, grants, and contributions, and that have no direct patient revenues.)

An alternative measure of uncompensated care is "unsponsored care"—that is, the cost of charity care plus bad debt, less any State and local government tax appropriation received by the hospital. Unsponsored care can be expressed in dollars or as a percentage of costs. The result is the amount that the hospital has to either absorb or pass on to private-pay patients. Survey data from AHA for 1989 indicate that unsponsored care reached 4.8 percent of hospital expenses, or $8.9 billion.

Though not the same, the issues of uncompensated care and care for the uninsured are closely related. According to a study conducted at the University of Florida on hospital care for the poor, patients classified as "self-pay" or "no-charge" accounted for approximately 70 percent of Florida hospitals' unpaid charges in 1985.[7] One analyst estimated, based on a national survey of hospitals, that 68 percent of hospitals' bad debts in 1982 were due to uninsured patients.[8]

Cost data from the AHA's annual surveys of community hospitals (including private, not-for-profit, investor-owned and State and local government hospitals) indicate that the amount of unsponsored care provided by hospitals has been increasing. In 1980, hospitals provided $2.8 billion in unsponsored care, representing 3.7 percent of total costs. In 1989, unsponsored care amounted to $8.9 billion (or 4.8 percent). According to the AHA, unsponsored care increased by 217 percent between 1980 and 1989, while overall hospital costs increased by 140 percent.

The burden of uncompensated care has been distributed unevenly across hospital types, with public hospitals providing a larger portion of uncompensated care in relation to total patient charges. Table 33 shows the distribution of unsponsored care by census region for 1989. Hospitals in the South Atlantic and East South Central States had the highest unsponsored care burden as a percentage of their total costs. This is consistent with data from previous years. Researchers have hypothesized that hospitals in the south have a higher burden of uncompensated care than those in the rest of the country because eligiblity for Medicaid programs in southern States has traditionally been more restrictive, and the south has a disproportionately high number of medically uninsured people.

---

[7] Center for Health Policy Research. "State University of Florida Study of Indigent Care. Analytic Report," v. 2, 1986 p. 271.

[8] Bizzoli, Gloria. "Heath Care for the Indigent. Overview of Critical Issues." Health Services Research, v. 21, No. 3, Aug. 1986, p. 379.

TABLE 33.—HOSPITAL UNSPONSORED CARE BY REGION, 1989

	Percent [1]
Region:	
New England	5.5
Middle Atlantic	4.1
South Atlantic	6.6
East North Central	3.7
East South Central	7.1
West North Central	3.2
West South Central	5.6
Mountain	5.1
Pacific	4.2

[1] Unsponsored care as a percentage of total expenses.

Source: American Hospital Association—Office of Public Policy Analysis. Based on AHA Annual Survey data for 1989.

Table 34 shows unsponsored care as a percentage of hospital costs by hospital bed-size for 1989. While data for earlier years suggested that larger hospitals furnished proportionately more unsponsored care than smaller ones, data for 1989, like that for 1988, suggest that this is no longer true. For example, a recent study by the Congressional Budget Office found that in 1988, 5.7 percent of the total costs of urban public hospitals were incurred for unsponsored care compared to 4.9 percent of the costs of rural public hospitals, 4.8 percent of investor-owned hospitals, and 4.7 percent of voluntary hospitals.[9]

---

[9] Congressional Budget Office. Trends in Health Expenditures by Medicare and the Nation. Washington. January 1991.

TABLE 34.—HOSPITAL UNSPONSORED CARE BY BED-SIZE, 1989

	Percent [1]
Bed-size:	
6 to 24	2.5
25 to 49	4.8
50 to 99	4.8
100 to 199	5.0
200 to 299	5.0
300 to 399	4.8
400 to 499	5.2
500 or more	4.5

[1] Unsponsored care as a percentage of total expenses.

Source: American Hospital Association—Office of Public Policy Analysis. Based on AHA Annual Survey data for 1989.

Other characteristics which might explain differences in the amount and proportion of uncompensated or unsponsored care provided by hospitals include the socioeconomic characterstics of the population in the hospital's market area, hospital ownership, teaching status, location (metropolitan/nonmetropolitan), patient demand for free or subsidized care, and the type of services provided.[10] Some of these characteristics are shown in table 35.

---

[10] Congressional Budget Office. Trends in Health Care Expenditures by Medicare and the Nation. Washington. January, 1991.

TABLE 35.—UNCOMPENSATED AND UNSPONSORED CARE, BY TYPE OF HOSPITAL, 1981 AND 1988

[As a percentage of costs]

Type of hospital	1981		1988	
	Uncompensated care	Unsponsored care	Uncompensated care	Unsponsored care
All hospitals	5.0	3.8	6.1	4.9
Urban	5.1	3.7	6.2	4.8
Rural	4.4	3.9	5.4	4.9
Major teaching	9.8	4.2	10.0	4.8
Other teaching	4.0	3.8	5.4	5.0
Nonteaching	3.9	3.5	5.1	4.8
Voluntary	3.8	3.7	4.9	4.7
Urban public	12.8	4.5	14.7	5.7
Rural public	5.3	3.8	6.4	4.9
Investor-owned	3.0	3.0	4.9	4.8
Disproportionate share	6.9	4.4	8.0	5.4
Nondisproportionate share	3.5	3.3	4.7	4.5

Notes: The total amount of uncompensated care provided in 1981 was $4.9 billion, or $6.2 billion when expressed in 1987 dollars. The total amount of uncompensated care provided in 1988 was $10.7 billion, or $10.2 billion in 1987 dollars.

"Disproportionate share" hospitals are those that receive additional payments from the Medicare program because they serve a disproportionately large share of low-income patients.

Source: Congressional Budget Office calculations using tabulations by the American Hospital Association (AHA), based on the AHA's 1981 and 1988 Annual Surveys and Medicare Cost Reports. Table reflects data reported or estimated for hospitals that were included in each data set (4,841 in 1981 and 4,880 in 1988).

INTERNATIONAL HEALTH SPENDING [11]

This section analyzes trends in health expenditures for 23 Organization for Economic Cooperation and Development (OECD) countries from 1960 to 1987. Table 36 illustrates total health expenditures as a percentage of gross domestic product (GDP). In 1960, the mean percent of GDP was 3.8 percent, with the United States being 36 percent higher than the average with 5.2 percent of GDP. By 1987, the overall mean percent of GDP comprised of health expenditures had increased to 7.5 percent while the United States health spending as a share of GDP had increased to 11.2 percent, some 50 percent greater than the overall average.

The second to the last column in table 36 presents per capita health expenditures denominated in U.S. dollars. The last column illustrates public health expenditures as a percent of total health spending. This ranged from 41 percent in the United States to over

---

[11] The data and analysis in this section are from Health Affairs, "Data Watch: International Health Spending and Utilization Trends," by George J. Schieber and Jean-Pierre Poullier, Fall 1988.

90 percent in Luxembourg, Norway, and Sweden, with an OECD average of 77 percent.

TABLE 36.—TOTAL HEALTH EXPENDITURE AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT [GDP], PER CAPITA HEALTH SPENDING AND PERCENT OF HEALTH EXPENDITURES PUBLICLY FINANCED, FOR SELECTED CALENDAR YEARS 1960–87

[In percent except per capita]

	1960	1965	1970	1975	1980	1985	1986	1987	Per capita 1987	Public 1987
Australia	4.6	4.9	5.0	5.7	6.5	7.0	7.1	7.1	$939	71.8
Austria	4.6	5.0	5.4	7.3	7.9	8.1	8.3	8.4	982	67.6
Belgium	3.4	3.9	4.0	5.8	6.6	7.2	7.2	7.2	879	76.9
Canada	5.5	6.1	7.2	7.3	7.4	8.4	8.7	8.6	1,483	74.8
Denmark	3.6	4.8	6.1	6.5	6.8	6.2	6.0	6.0	792	85.5
Finland	3.9	4.9	5.7	6.3	6.5	7.2	7.3	7.4	949	78.5
France	4.2	5.2	5.8	6.8	7.6	8.6	8.7	8.6	1,105	78.3
Germany	4.7	5.1	5.5	7.8	7.9	8.2	8.1	8.2	1,093	77.0
Greece	3.2	3.6	4.0	4.1	4.3	4.9	5.3	5.3	337	75.3
Iceland	1.2	2.8	4.3	5.9	6.4	7.3	7.7	7.8	1,241	88.6
Ireland	4.0	4.4	5.6	7.7	8.5	8.0	7.8	7.4	561	87.0
Italy	3.3	4.0	4.8	5.8	6.8	6.7	6.6	6.9	841	78.0
Japan	2.9	4.3	4.4	5.5	6.4	6.6	6.7	6.8	915	73.2
Luxembourg	–	–	4.1	5.7	6.8	6.7	6.8	7.5	1,050	91.6
Netherlands	3.9	4.4	6.0	7.7	8.2	8.3	8.3	8.5	1,041	77.8
New Zealand	4.4	4.5	5.1	6.4	7.2	6.6	6.9	6.9	733	82.5
Norway	3.3	3.9	5.0	6.7	6.6	6.4	7.1	7.5	1,149	97.6
Portugal	–	–	–	6.4	5.9	7.0	6.6	6.4	386	60.2
Spain	2.3	2.7	4.1	5.1	5.9	6.0	6.1	6.0	521	71.5
Sweden	4.7	5.6	7.2	8.0	9.5	9.4	9.1	9.0	1,233	90.6
Switzerland	3.3	3.8	5.2	7.0	7.3	7.7	7.6	7.7	1,225	68.2
United Kingdom	3.9	4.1	4.5	5.5	5.8	6.0	6.1	6.1	758	86.6
United States	5.2	6.0	7.4	8.4	9.2	10.6	10.9	11.2	2,051	41.4
Mean	3.8	4.5	5.3	6.5	7.0	7.4	7.4	7.5	NA	77.4

Source: Schieber, George J. and Jean-Pierre Poullier. "International Health Care Expenditure Trends: 1987." Health Affairs, Fall 1989 pp. 169–177.

APPENDIX D. MEDICARE REIMBURSEMENT TO HOSPITALS [1]

Medicare part A provides reimbursement for inpatient hospital care through a payment system based on prospectively set rates, the prospective payment system (PPS), for hospital cost reporting periods beginning on or after October 1, 1983.

Before the passage of the Social Security Amendments of 1983 (P.L. 98-21) the Medicare program reimbursed hospitals according to the reasonable costs they incurred in providing services to Medicare beneficiaries. Because the actual reasonable costs could not be determined until after the hospital had provided the services and reported its costs to the Medicare program, this method of reimbursement was known as retrospective cost-based reimbursement.

Under authority provided by the Social Security Amendments of 1972 (P.L. 92-603), the Department of Health and Human Services (HHS) placed certain limits on inpatient routine operating costs recognized as reasonable (referred to as section 223 limits for the specific section in the law). The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, commonly referred to as TEFRA) expanded previously existing limits to include all other inpatient hospital operating costs. Further, it established a new 3-year Medicare ceiling (or target rate) on the allowable annual rate of increase in operating costs per case for inpatient hospital services. TEFRA also required that HHS develop proposals for the prospective payment of hospitals under Medicare. The proposal from HHS was presented to the Congress at the end of 1982.

Legislation based on this prospective payment proposal was enacted in Public Law 98-21, which established a new method of Medicare reimbursement for hospital inpatient care—the prospective payment system (PPS). This appendix describes the major reimbursement provisions of PPS.

GENERAL SUMMARY

Medicare payment for hospital inpatient services is made according to a prospective payment system, rather than a retrospective cost-based system. Medicare payments are made at predetermined, specific rates which represent the average cost, nationwide, of treating a Medicare patient according to his or her medical condition. The classification system used to group hospital inpatients according to their diagnoses is known as diagnosis-related groups (DRGs). Separate DRG rates apply depending on whether a hospital is located in a large urban area (greater than 1 million population, or 970,000 in New England), other urban area, or rural area of the country, as determined by the Office of Management and Budget (OMB) Metropolitan Statistical Area (MSA) system.

---

[1] This appendix draws heavily from a Congressional Research Service issue brief entitled: "Medicare: Prospective Payments for Inpatient Hospital Services."

During a 4-year transition period, a declining portion of the total prospective payment was based on a hospital's historical reasonable costs and an increasing portion was based on a combination of regional and national Federal DRG rates. In the fifth year of the program (fiscal year 1988) and thereafter, Medicare payments are generally determined under a national DRG payment methodology. Special transition provisions apply to hospitals located in certain geographic regions.

If a hospital can treat a patient for less than the payment amount, it can keep the savings. If the treatment costs more, the hospital must absorb the loss. A hospital is prohibited from charging Medicare beneficiaries any amounts (except for deductibles, copayment amounts, and for services not covered by Medicare) which represent any difference between the hospital's cost of providing covered care and the Medicare DRG payment amount.

Certain hospital costs are excluded from the prospective payment system and are paid on a reasonable cost basis. In addition, certain hospitals are excluded from the new system and continue to be reimbursed on a reasonable cost basis, subject to rate of increase limits. Authority is provided for States to establish their own all-payer hospital payment systems if they meet certain Federal requirements.

Basic Payment System

Unless excluded from the prospective payment system, each Medicare participating hospital is paid a predetermined payment rate per discharge for each type of patient treated. Types of patients are defined by the diagnosis related groups patient classification system which assigns each hospital inpatient to one of 485 patient categories (DRGs) based on the diagnosis and the type of treatment received (medical or surgical).

The payment rate for each DRG is the product of two components: a base payment amount which applies for all DRGs, and a relative weighting factor for the particular DRG. The base payment amount is intended to represent the cost of a typical (average) Medicare inpatient case. The relative weighting factor represents the relative costliness of an average case in the particular DRG compared to the cost of the overall average Medicare case (i.e., relative to the base payment amount). When the DRG relative weights are each multiplied by the base payment amount, the result is a complete set of prices for all DRGs. Separate DRG rates apply to hospitals located in large urban, other urban, or rural areas (separate base payment amounts apply in these areas, but the DRG relative weighting factors are the same). In addition, the base payment amount (and, therefore, each DRG rate) is adjusted for area differences in hospital wage levels compared to the national average hospital wage level.

Transition period

Although the transition to prospective payment rates was completed in fiscal year 1988, special transition provisions apply to hospitals located in certan geographic regions.

In a few regions with historically higher costs, Public Law 100-203 provided for the continued use of Federal amounts based in part on regional rates until September 30, 1990. Under this transition provision, known as the "regional floor," the DRG payment rate is determined as the higher of 100 percent of the national amount, or 85 percent of the national amount plus 15 percent of the regional amount.

Public Law 101-403, the Continuing Resolution of October 1, 1990, extended the regional floor provision on a budget neutral basis through October 20, 1990. Public Law 101-508 (OBRA 1990) extends the regional floor provision for discharges occurring before October 1, 1993, not subject ot budget neutrality.

Update factors

PPS payment rates are updated each year using an "update factor." The annual update factor applied to increase the Federal base payment amounts is determined, in part, by the projected increase in the hospital market basket index. The market basket index measures the cost of goods and services purchased by hospitals, yielding one price inflator for all hospitals in a given year. Table 1 shows the categories of expense used in developing the index. The update factor also includes adjustments for increases in hospital productivity, technological change, and other factors that affect the level of operating cost per discharge. The annual update factor is also adjusted to include increases in average payments per case attributable to increases in case mix due to changes in coding and reporting accuracy.

Before fiscal year 1988, the same factor was used for all hospitals; however, in subsequent years separate factors have applied to hospitals according to their location. Separate update factors have been set for hospitals located in large urban, other urban and rural areas of the country.

From October 1, 1990, through October 20, 1990, the PPS hospital update factors were set equal to the full market basket increase. Public Law 101-508 provided for a freeze in hospital payments at fiscal year 1990 levels for the period from October 21, 1990, through December 31, 1990. For this period, the market basket percentage increase applicable to PPS and PPS-exempt hospitals was deemed to be equal to zero (0) percent.

OBRA 1990 (Public Law 101-508) sets separate update factors for hospitals located in large and other urban areas, and for hospitals located in rural areas. For large and other urban hospitals, the following update factor are: for fiscal year 1991, for discharges occurring on or after January 1, 1991, the market basket increase (MBI) minus 2.0 percentage points; for fiscal year 1992, the MBI minus, 1.6 percentage points; for fiscal year 1993, the MBI minus 1.55 percentage points; and for fiscal year 1994-95, the full MBI.

TABLE 1.—HOSPITAL PROSPECTIVE PAYMENT INPUT PRICE INDEX (THE "MARKET BASKET")

Expense categories	Relative importance [1]				Projected increase 1992 (percent)
	1982	1987	1990	1991	
1. Wages and Salaries [2]	5047	52.24	51.86	52.05	4.5
2. Employee Benefits [2]	8.92	9.47	10.02	10.027	6.1
3. Professional Fees [2]	1.58	1.65	1.63	1.65	4.6
4. Energy and Utilities	3.70	2.46	2.40	2.26	−9.2
a. Fuel, Oil, Coal, and Other Petroleum	1.41	0.69	0.73	0.67	−22.6
b. Electricity	1.23	1.15	1.06	1.02	1.7
c. Natural Gas	0.52	0.33	0.28	0.29	0.8
d. Motor Gasoline	0.51	0.25	0.29	0.25	−25.2
e. Water and Sewage	0.03	0.04	0.04	0.04	8.3
5. Malpractice Insurance	0.71	1.48	1.60	1.55	5.0
6. All Other	34.63	32.71	32.50	32.24	2.7
All Other Products	23.35	21.75	21.70	21.40	2.1
a. Pharmaceuticals	3.03	3.93	4.33	4.49	8.0
b. Food	3.54	3.29	3.21	3.17	3.5
(1) Contract Service	1.18	1.19	1.17	1.17	2.3
(2) Direct Purchase	2.36	2.10	2.05	2.00	5.5
c. Chemicals and Cleaning Products	3.93	3.15	3.18	3.08	−3.1
d. Surgical and Medical Instruments	2.97	2.64	2.48	2.40	1.3
e. Photographic Supplies	2.84	2.60	2.60	2.47	−0.2
f. Rubber and Plastics	2.72	2.31	2.19	2.16	0.9
g. Paper Products	1.48	1.39	1.41	1.38	2.3
h. Apparel	1.34	1.13	1.05	1.01	0.2
i. Minor Machinery Equipment	0.54	0.49	0.46	0.45	2.3
j. Miscellaneous Products	0.95	0.83	0.80	0.79	0.4
All Other Services	11.28	10.96	10.81	10.85	3.9
a. Business Services [2]	4.03	3.79	3.78	3.76	4.1
b. Computer and Data Processing Services [2]	1.81	2.01	2.12	2.14	5.7
c. Transportation and Shipping		1.24	1.21	1.25	2.3
d. Telephone	0.95	0.97	0.84	0.82	1.9
e. Blood Services [2]	0.65	0.56	0.53	0.52	2.5
f. Postage [2]	0.40	0.37	0.36	0.40	4.7
g. All Other Services: Labor Intensive [2]	1.22	1.22	1.17	1.17	3.8
h. All Other Services: Nonlabor Intensive	0.83	0.80	0.79	0.79	3.0
Total	100.00	100.00	100.00	100.00	3.8

[1] These weights are used to develop the revised labor-related/nonlabor-related components of the standardized rates.

[2] Considered labor-related.

Source: Health Care Financing Administration, Office of the Actuary, March 1991.

The update factors for rural hospitals are: for fiscal year 1991, for discharges occurring on or after January 1, 1991, the MBI minus 0.7 percentage points; for fiscal year 1992, the MBI minus 0.6 percentage points; for fiscal year 1993, the MBI minus 0.55 percentage points; for fiscal year 1994, the MBI plus 1.5 percentage points; and for fiscal year 1995, the amount necessary to provide rural hospitals with an average standardized amount equal to that of other urban hospitals.

For fiscal year 1991, the market basket increase is estimated to be 5.2 percent, providing the following net fiscal year 1991 update factors, for discharges occurring on or after January 1, 1991: for large and other urban hospitals, 3.2 percent; for rural hospitals, 4.5 percent.

OBRA 1990 also includes a phaseout of the payment differential between other urban and rural hospitals. The law would set separate update factors for urban and rural hospitals designed to eliminate the differences between other urban and rural standardized amounts by fiscal year 1995.

DRG weighting factors

Public Law 98-21 required the HHS Secretary to adjust the DRG definitions and weighting factors in fiscal year 1986 and at least every 4 years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. Public Law 99-509, however, required the Secretary to adjust the DRG definitions and weighting factors each year, beginning in fiscal year 1988.

OBRA 1989 required the Secretary to reduce the weighting factor for each DRG by 1.22 percent for discharges in fiscal year 1990. In addition, the Secretary is prohibited from adjusting DRG weighting factors on other than a budget neutral basis beginning in fiscal year 1991.

Table 2 shows the 20 DRGs accounting for the largest numbers of Medicare inpatient discharges during fiscal year 1989. Information about all DRGs appears in table 22 at the end of this appendix.

Source and calculation of the hospital wage index

The hospital wage index is used to adjust a hospital's base payment amount for the wage level of the hospital's area. This is accomplished by multiplying the labor-related component of the Federal portion of the payment amount by a wage index. The wage index is intended to measure the average wage level for hospital workers in each urban area (metropolitan statistical area or MSA) or rural area (non-MSA parts of States) relative to the national average wage level.

TABLE 2.—SHORT STAY HOSPITAL DISCHARGES, BY RANK ORDER OF THE TWENTY DIAGNOSIS-RELATED GROUPS WITH THE MOST DISCHARGES IN 1989

DRG number and description	Discharges (in thousands)	Percent of total	Rank	Average length of stay
Total DRGs	9,879.5	100.0		
20 Leading DRGs	4,043.3	40.9		
127 Heart failure and shock	539.5	5.5	1	8.0
140 Angina pectoris	359.0	3.6	2	4.8
089 Simple pneumonia and pluerisy [1]	348.3	3.5	3	9.1
014 Specific cerebrovascular disorders except transient ischemic attack	325.2	3.3	4	10.7
182 Esophagitis, gastroent and miscellaneous digestive disorders [1]	243.6	2.5	5	6.5
096 Bronchitis and asthma	215.0	2.2	7	7.3
209 Major joint and limb reattachment procedures	218.7	2.2	6	12.0
296 Nutritional and miscellaneous metabolic disorders [1]	196.6	1.9	8	8.8
138 Cardiac arrhythmia and conduction disorders with cardiovascular complications	171.2	1.7	9	6.2
015 Transient ischemic attack and precerebral occlusions	139.2	1.4	14	5.6
320 Kidney and urinary tract infections [1]	145.0	1.5	11	8.8
121 Circulatory disorders with acute myocardial infarction and cardiovascular complications, discharged alive	146.1	1.5	10	10.2
410 Chemotherapy	140.5	1.4	12	3.5
174 G.I. hemorrhage with cardiovascular complications	140.2	1.4	13	7.1
243 Medical back problems	120.2	1.2	18	6.9
122 Circulatory disorders with acute myocardial infarction	120.9	1.2	17	7.3
148 Major small and large bowel procedures with cardiovascular complications	130.6	1.3	15	17.3
416 Septecemia	113.3	1.1	19	10.8
079 Respiratory infections and inflammations [1]	111.2	1.1	20	12.5
112 Percutaneous cardiovascular procedures	124.0	1.3	16	7.3

[1] Age greater than 17 with complications.

Source: 55 FR 35990.

Until May 1, 1986, the index was based on compensation and employment data for hospital workers, for calendar year 1981, as reported to the Bureau of Labor Statistics in the U.S. Department of Labor. The wage index reflected average hospital wages in each urban and rural area as a percentage of the national average hospital wage. However, because many hospitals relied on varying proportions of part-time employment, there was a concern that the wage index tended to understate actual levels of hospital hourly wage rates in facilities that relied heavily on part-time workers.

In final regulations published on September 1, 1987 (52 FR 33039, Sept. 1, 1987), the Secretary changed the method of calculating the national average wage level, and updated the wage index data. The national average wage level was calculated by dividing national aggregate wages and salaries by the national aggregate number of paid hours of hospital employment. Under this method, the index as a whole was not likely to be sensitive to minor changes in the data for individual labor market areas. The Secretary also decided to implement a new wage index based on data for wages and salaries and paid hours of employment for hospital cost reporting periods beginning during fiscal year 1984 (the first year of the PPS). However, in order to avoid large changes in index values for individual areas, which could result if the index based on 1984 data completely replaced the previous index (based on 1982 data), the Secretary adopted a blended wage index. The blended wage index value for each area was calculated by adding together the 1982 and the 1984 index values for the area and dividing the resulting sum by 2. Wage index values for urban and rural labor market areas located in Puerto Rico were based solely on 1984 data. The new index took effect for discharges occurring in fiscal year 1988. A new wage index, based solely on 1984 data, was proposed May 27, 1988, to apply to discharges in fiscal year 1989. However, in the final rule published September 30, 1988, the Secretary chose to continue to use the blended wage index for discharges in fiscal year 1989.

In final regulations published September 1, 1989 (54 FR 36452), the Secretary changed the method of calculating the wage index from the blended wage index based on 1982 and 1984 wage data to an index based solely on 1984 wage data. Tables 20 and 21, at the end of this appendix, give the current wage index values for each metropolitan area and for rural areas in each State.

Public Law 100-203 (OBRA 1987) required the Secretary to update the wage index by October 1, 1990, and at least every 3 years thereafter. Updates are to be based on a periodic survey of the wages and wage related costs of PPS hospitals. To the extent feasible, the survey must be designed to measure earnings and hours of paid employment by occupational category, and to permit exclusion of the wages and wage related costs hospitals incur in providing skilled nursing facility services.

OBRA 1989, also requires the Secretary to update the area wage index annually, beginning in fiscal year 1993, in a budget neutral manner.

The September 4, 1990, final rule (55 FR 35990) set forth a revised hospital wage index that was based on a HCFA survey of hopital wage and salary data for all hospitals subject to PPS with cost reporting periods ending in calendar year 1988. The final rule also included a 1-year phasein of the new wage index for fiscal year 1991, in order to lessen the impact of the most significant changes in wage index values. The final rule limited the percentage change in the wage index value to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value.

Public Law 101-403 required the continued use of the wage index in effect on September 30, 1990, from October 1, 1990, through October 20, 1990. Public Law 101–508 extends the use of the fiscal year 1990 wage index for discharges occurring on or after October 21, 1990, and before January 1, 1991. For discharges occurring on or after January 1, 1991, and before October 1, 1993, OBRA 1990 requires the use of a wage index based solely on the 1988 wage survey. OBRA 1990 requires the Secretary to apply the wage index without regard to previous surveys of wages and wage-related costs. In addition, OBRA 1990 requires ProPAC to study the available data on wages by occupational category and include their recommendations in its March 1991 report on modifying the wage index to take into account occupational mix.

The calculation of the index begins with the area average hospital hourly wage. For each MSA or non-MSA area (i.e., all non-MSA counties in a State) total county compensation and total paid hours data are summed separately over all counties included in the area. Then aggregate hospital compensation for the area is divided by aggregate paid hours of hospital employment in the area to produce the area average hourly wage. The hospital wage index is calculated by dividing the average hourly wage for each area by the national average hourly wage (determined by dividing national aggregate compensation by national aggregate paid hours of employment).

This procedure results in an index number, such as 0.8756 (Asheville, North Carolina) or 1.2257 (Sacramento, California) for each MSA or non-MSA area in the United States. Since the national average wage level is represented by an index value of 1.000, the wage index value for any area has a direct and simple interpretation. The value of 1.2257 for Sacramento means that the average hourly wage rate for hospital workers is 22.57 percent higher in the Sacramento MSA than the national average hourly wage rate.

Thus, in computing the Federal portion of the hospital payment rates applicable for hospitals in the Sacramento MSA, the labor-related component of the national urban adjusted standardized payment amount ($2,480.60) is multiplied by 1.2257 in order to adjust for the higher level (22.57 percent) of hospital hourly wage rates in this area. Similarly, the calculation of the Federal portion of the rates for hospitals in Asheville would involve a reduction in the published labor-related component of the national adjusted standardized payment amount, to reflect the fact that average hourly wage levels in this MSA are 12.44 percent lower than the national average (as indicated by the wage index value of 0.8756).

SAMPLE PAYMENT CALCULATION

The Federal large urban, other urban, and rural base payment amounts per discharge for fiscal year 1991 were published in the Federal Register on January 7, 1991 (see table 3).[2] Although Federal urban and rural payment amounts are included for each region, after November 21, 1987, the regional amounts are applied in determining payment rates only for sole community hospitals and hospitals located in regions affected by the regional floor.

---

[2] Three different standardized amounts are in effect during fiscal year 1991. Public Law 101–403 required revised standardized amounts as a result of the extension of the regional floor provisions from October 1, 1990, to October 20, 1990, on a budget neutral basis. Public Law 101–508 (OBRA 1990) provides for a freeze in hospital payments for the period from October 21, 1990, through December 31, 1990, requiring revised standardized amounts. In addition, OBRA 1990 applies new update factors to standardized amounts for discharges occurring on or after January 1, 1991, and before September 30, 1991.

Each payment amount is divided into a labor-related component and a nonlabor related component. The sum of these components represents the base payment amount that would apply for a hospital located in an area with a wage index of 1.0 (i.e., average wage rates for hospital workers in the area match the national average of hospital wage rates across all areas).

The basic payment to a hospital for a case in a particular DRG is the applicable national (or in some cases, a blend of the national and regional) payment amount, adjusted by the local wage index value and multiplied by the weighting factor for the DRG.

For an example of a payment calculation, assume a hospital is located in Washington, D.C. Such a hospital would be in a large urban area in census region 3. As this is not one of the regions affected by the regional floor, payment is based on the large urban national standardized amount. First the labor-related portion of this amount ($2,480.60 in fiscal year 1991) is multiplied by the appropriate wage index (1.0962 for Washington, D.C.):

$$\$2{,}480.60 \times 1.0962 = \$2{,}719.23$$

To this total is added the nonlabor-related portion of the standardized amount:

$$\$2{,}719.23 + \$1{,}021.98 = \$3{,}741.21$$

For each discharge this new total is then multiplied by the relative weight for the DRG to which the case has been assigned. These weights range from a low of 0.1101 for DRG 382 (false labor) to a high of 15.2645 for DRG 480 (liver transplant). The payment rates for the sample hospital in fiscal year 1991 would therefore vary from a low of $411.91 ($3,741.21×0.1101) to a high of $57,107.70 ($3,741.21×15.2645). This payment would be reduced by the Medicare inpatient deductible amount ($628 per spell of illness in calendar 1991).

TABLE 3.—REGIONAL AND NATIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR, FISCAL YEAR 1991 [1]

[In dollars]

	Large urban		Other urban		Rural	
	Labor related	Nonlabor related	Labor related	Nonlabor related	Labor related	Nonlabor related
New England (CT, ME, MA, NH, RI, VT)	2,605.03	1,067.16	2,563.78	1,050.26	2,699.37	930.96
Middle Atlantic (PA, NJ, NY)	2,340.38	1,011.01	2,303.33	995.00	2,585.18	880.07
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,498.28	933.05	2,458.72	918.28	2,471.32	763.14
East North Central (IL, IN, MI, OH, WI)	2,635.08	1,103.96	2,593.36	1,086.48	2,502.54	848.17
East South Central (AL, KY, MS, TN)	2,397.66	844.86	2,359.69	831.49	2,449.34	711.64
West North Central (IA, KS, MN, MO, NE, ND, SD)	2,498.99	1,005.89	2,459.43	989.96	2,380.58	760.28
West South Central (AR, LA, OK, TX)	2,484.61	926.73	2,445.27	912.07	2,283.07	699.19
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,396.76	992.66	2,358.82	976.94	2,308.79	804.17
Pacific (AK, CA, HI, OR, WA)	2,331.39	1,133.90	2,294.48	1,115.95	2,245.50	905.93
Puerto Rico [2]	2,231.04	464.00	2,195.71	456.65	1,659.58	357.77
National	2,480.60	1,021.98	2,441.33	1,005.80	2,434.74	784.43

[1] Effective Jan. 1, 1991.

[2] For calculating Puerto Rico's payments, a separate national adjusted standardized amount is used. Puerto Rico's payments are a blend of the Puerto Rico specific amount and a special national amount. In 1991, the labor-related amount is $2,454.71 and the nonlabor-related amount is $956.00.

Source: 56 FR 576.

In addition to the basic payment for each case, additional payments may be made to teaching hospitals and hospitals that serve a disproportionate share of low-income patients. Any hospital may receive additional payments for outliers (cases with extraordinarily high costs or a very long stay, relative to other cases in the DRG) and for treatment of beneficiaries with end stage renal disease. Finally, certain hospital costs, such as those related to capital, are excluded from PPS and reimbursed separately. The next sections of this appendix discuss additional PPS payments and the separate reimbursement of excluded costs.

ADDITIONAL PAYMENT AMOUNTS

In addition to the DRG prospective payment rates, Medicare payments are made to hospitals for the following items or services:

Indirect medical education costs

Additional payments are made to hospitals under the prospective system for the indirect costs attributable to approved medical education programs. These indirect costs may be due to a variety of factors, including the extra demands placed on the hospital staff as a result of the teaching activity or additional tests and procedures that may be ordered by residents. Congressional reports on the PPS authorizing legislation indicate that the indirect medical education payments are also to account for factors not necessarily related to medical education which may increase costs in teaching hospitals, such as more severely ill patients, increased use of diagnostic testing, and higher staff-to-patients ratios.

The additional payment to a hospital is based on a formula that provides an increase of approximately 7.7 percent in the Federal portion of the DRG payment, for each 0.1 increase in the hospital's intern and resident to bed ratio on a curvilinear or variable basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size).

Public Law 100-647 extended the 7.7 percent indirect medical education adjustment until October 1, 1995. Public Law 101-508 makes the indirect medical education adjustment of 7.7 percent permanent.

Disproportionate share hospitals

Public Law 99-272 (COBRA) provided that additional payments would be made to hospitals that serve a disproportionate share of low-income patients; the adjustment was extended until October 1, 1990, by OBRA 1987 (Public Law 100-203) and to October 1, 1995 by Public Law 100-647, the Technical and Miscellaneous Revenue Act (TAMRA) of 1988. A hospital's disproportionate patient percentage is defined as the hosptial's total number of inpatient days attributable to Federal Supplemental Security Income Medicare beneficiaries divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days.

Public Law 101-508 (OBRA 1990), revised the formulas for computing the disproportionate share adjustment, effective January 1, 1991. Table 4 shows the minimum disproportionate patient percentages required to qualify for the adjustment and the formulas for computing the adjustment effective January 1, 1991.

OBRA 1990 provides for additional increases in disproportionate share hospital payments beginning in fiscal year 1994 for urban hospitals with 100 or more beds. For discharges occurring on or after October 1, 1993, such hospitals with a disproportionate patient percentage over 20.2 percent are scheduled to receive payments based on the following formula: (P-20.2)(.8) + 5.88; hospitals with a disproportionate patient percentage between 15 and 20.2 are scheduled to receive payments based on the formula: (P-15)(.65) + 2.5.

TABLE 4.—CRITERIA TO QUALIFY FOR DISPROPORTIONATE SHARE ADJUSTMENT AND FORMULAS FOR COMPUTING ADDITIONAL PAYMENT, EFFECTIVE JANUARY 1, 1991

Type of hospital	Qualifying disproportionate patient percentage (P)	Formula or fixed percentage adjustment
Urban, 100 or more beds	15 percent	(P–15)(.6) + (2.5)
Urban, 100 or more beds	20.2 percent	(P–20.2)(.7) + (5.62)
Urban, 100 or more beds	30 percent of inpatient revenue from State or local indigent care funds.	35 percent
Urban, under 100 beds	40 percent	5 percent
Rural, over 500 beds	Not specified in law; regulations set threshold at 15 percent.	Same as urban, 100 or more beds
Rural, over 100 beds	30 percent	4 percent
Rural, under 100 beds	45 percent	4 percent
Rural, sole community hospital.	30 percent	10 percent
Rural, rural referral center and—		
(a) not a sole community hospital, 100 or more beds.	30 percent	(P–30)(.6) + 4.0
(b) not a sole community hospital, under 100 beds.	45 percent	(P–30)(.6) + 4.0
(c) also a sole community hospital.	30 percent	Greater of 10 percent or (P–30)(.6) + 4.0

Note: The disproportionate patient percentage (P) is equal to the sum of (a) the number of Medicare inpatient days provided to Supplemental Security Income recipients divided by total Medicare patient days, and (b) the number of inpatient days provided to Medicaid beneficiaries divided by total inpatient days.

Source: Congressional Research Service.

Direct medical education costs

The direct costs of approved medical education programs (such as the salaries of residents and teachers and other education costs for residents, and for nurses, and allied health professionals trained in provider-operated programs) are excluded from the prospective payment system. The direct medical education costs for the training of nurses and allied health professionals in provider-operated programs are paid for on a reasonable cost basis.

Public Law 99–272 (COBRA), replaced reasonable cost reimbursement for graduate medical education through residency training programs for physicians, with formula payments based on each hospital's per resident costs. Medicare's payment to each hospital equals the hospital's cost per full-time equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE resident amount is calculated using data from the hospital's cost reporting period that began in fiscal year 1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. The number of FTE residents is calculated at 100 percent after July 1, 1986, only for residents in their initial residency period (i.e., within the minimum number of years of formal training necessary to satisfy specialty requirements for board eligibility plus 1 year, but not to exceed 5 years). For residents not in their initial residency period, the weighing factor is 75 percent before July 1, 1987, and 50 percent after that date. On or after July 1, 1986, residents who are foreign medical graduates are not to be counted as FTE residents unless they have passed certain designated examinations.

HHS issued final regulations implementing the COBRA payment changes for graduate medical education costs on September 29, 1989. The changes are effective retroactively to 1985. OBRA 1990, prohibits the Secretary from recouping overpayments to hospitals resulting from the COBRA payment changes for graduate medical education until October 1, 1991. In addition, the act limits the amount of the recoupment to 25 percent of the total overpayment in each of four years beginning in fiscal year 1992.

In addition, Public Law 101–508 provides for a freeze in the update applicable for graduate medical education per-resident payment amounts for portions of cost reporting periods occurring from October 21, 1990, through December 31, 1990.

Hospital-based nursing and allied health professionals education programs operated at a hospital but controlled by another institution were included in PPS payment rates until an exception was enacted in TAMRA, allowing hospitals paid under a demonstration waiver to receive reasonable cost reimbursement for the costs of the nursing school. Public Law 101–239 allowed such hospitals to continue to be reimbursed on a reasonable cost basis if, before June 15, 1989, and thereafter, the hospital incurred substantial costs in training students and operating the school, the nursing school and hospital share some common board members, and all instruction is provided at the hospital or in the immediate proximity of the hospital. In addition, hospitals paid under the TAMRA exception will be allowed to be reimbursed for reasonable costs of training nursing students retroactively for hospital cost reporting periods beginning in fiscal year 1986.

OBRA 1990 provides for payment on a passthrough basis (exempt from PPS) to hospitals for the clinical training of nurses or allied health education programs that are hospital-supported, as distinct from hospital-operated. The act requires hospitals to meet specific requirements to qualify for such payments, including the requirement that hospitals must have claimed and been paid for such costs prior to October 1, 1989. The Secretary is prohibited from recouping overpayments made to such hospitals and is required to refund any overpayments already recouped.

ESRD beneficiary discharges

Effective with cost reporting periods beginning on or after October 1, 1984, additional payments are made to hospitals for inpatient dialysis provided to end-stage renal disease (ESRD) beneficiaries if total discharges of such beneficiaries from non-ESRD related DRGs account for 10 percent or more of the hospital's total Medicare discharges. A hospital meeting the criteria is paid an additional payment for each ESRD beneficiary discharge based on the estimated weekly cost of dialysis and the average length of stay of its ESRD beneficiaries.

Outliers

Additional amounts are paid to hospitals for atypical cases (known as "outliers") which have either extremely long length of stay (day outliers) or extraordinarily high costs (cost outliers) compared to most discharges classified in the same DRG. The law requires that total outlier payments to all hospitals covered by the system represents no less than 5 percent and no more than 6 percent of the total estimated PPS payments for the fiscal year. Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases meeting the criteria for cost outliers. Outlier payments are financed by an offsetting overall reduction in the Federal portion of the base payment amount per discharge. Effective October 1, 1986, Public Law 99-509 established separate urban and rural set-aside factors for financing outlier payments. The separate set-aside factors for rural and urban hospitals for financing outlier payments will end when the other urban/rural payment differential is phased out in fiscal year 1995, as enacted in OBRA 1990.

Public Law 100-203 increased payments for outlier cases classified in DRGs relating to patients with burns from April 1, 1988, through September 30, 1989. This legislation also prohibited the Secretary from issuing any final regulations before September 1, 1988, which change the method of payment for outlier cases (other than burn cases).

The Secretary published new outlier rules on September 30, 1988, effective for discharges on or after October 1, 1988. The new rules modify the thresholds used in determining whether a case is an outlier and increase the allowable payment amounts for cost outliers. The effect of the changes is to increase the proportion of all outlier payments going to cost outliers. Previously, about 85 percent of outlier payments were made for length of stay outliers and 15 percent for cost outliers. Under the new rules, 60 percent of payments will be made for cost outliers and 40 percent for length of stay outliers. (Cases that meet both length of stay and cost outlier criteria are paid under the policy that produces the higher payment.)

To determine the amount of additional payments for outlier cases, the length of stay (LOS) for each case in a DRG is first compared against the applicable LOS threshold for the category. If the LOS for a case exceeds the threshold, then the case qualifies as a day outlier. In this instance, the hospital is paid its regular payment rate per discharge (for this DRG), plus the Federal portion of a per diem amount (60 percent of the hospital's Federal per diem rate for the DRG) for each Medicare covered day above the LOS threshold.

If the case does *not* qualify as a day outlier, then it may qualify as a cost outlier. The case will qualify for extra payments on this basis if the hospital's Medicare covered charges for the case, adjusted to operating costs (and reduced by its indirect teaching and disproportionate share adjustments, if applicable), exceed its cost outlier threshold for the DRG. In this instance, the hospital is paid its regular payment rate per discharge for the DRG, plus the Federal portion of 70 percent of the difference between its adjusted (and reduced) charges for the case and the cost outlier threshold.

Table 5 shows the changes in outlier policy that have occurred during the last 6 years of the PPS.

TABLE 5.—FISCAL YEAR 1986–1991 OUTLIER POLICY PARAMETERS

	1986 [1]	1987	1988	1989 [2]	1990	1991
Pool target	5.0%	5.4% (urban) 2.2% (rural)	5.6% (urban) 2.5% (rural)	5.6% (urban) 2.2% (rural)	5.6% (urban) 2.2% (rural)	5.5% (urban) 2.3% (rural)
Federal portion	55.0%	75.0%	100.0%	100%	100%	100%
Length of stay thresholds [3].	Lesser of 17 days or 1.94 x S.D.	Lesser of 17 days or 1.94 x S.D.	Lesser of 18 days or 2.00 x S.D.	Lesser of 24 days or 3.00 x S.D.	Lesser of 28 days or 3.00 x S.D.	Lesser of 29 days or 3.0 x S.D.
Cost thresholds	Greater of 2.0 x DRG Federal rate or $13,500	Greater of 2.0 x DRG Federal Rate or $13,500	Greater of 2.0 x DRG Federal rate or $14,000	Greater of 2.0 x DRG Federal rate or $28,000	Greater of 2.0 x DRG Federal rate or $34,000	Greater of 2.0 x DRG Federal rate or $35,000
Cost-to-charge ratio used for cost outliers.	72.0%	66.0%	66.0%	Hospital-specific	Hospital-specific	Hospital specific
Marginal cost factor	60.0%	60.0%	60.0%	60.0% (length of stay), 75.0% (cost)	60.0% (length of stay), 75.0% (cost)	60% (length of stay) 75% (cost)

---

[1] The outlier policy for fiscal year 1986 was effective May 1, 1986.

[2] Effective for discharges after October 31, 1988. For discharges between October 1 and October 31, 1988, transitional thresholds applied as follows; length of stay, lesser of 22 days or 2 standard deviations; cost, greater of 2 times Federal rate or $23,750.

[3] The LOS threshold for a DRG is set at the lesser of the national average LOS for all cases in the DRG plus a fixed number of days (e.g., 20 days in fiscal year 1984) or the national average LOS for the DRG plus a fixed number of standard deviations (e.g., 1.94 SD in fiscal year 1984). The number of days represented by a fixed number of standard deviations varies among the DRG categories.

Source: Annual Federal Register notices.

PAYMENTS ON A REASONABLE COST BASIS

Costs for certain items are excluded from the prospective payment system and thus are not included in the prospective payment rates. Medicare pays for its share of the following costs according to the former reasonable cost-based system:

Capital-related costs

Medicare pays its proportionate share of hospitals' reasonable capital-related costs, based on services used by beneficiaries as a proportion of total services furnished by the hospital. (Payments in recent years have been subject to fixed percentage reductions to be described below.) Four basic types of costs are allowable for Medicare reimbursement:

(1) Interest on mortgages, bonds, or other borrowing used to finance capital investments or current operations. Interest costs are generally offset by any interest income earned by the hospital on investments.

(2) Depreciation, figured on a straight line basis, for plant and equipment, but not for land.

(3) Rental payments for plant and equipment.

(4) Property taxes and insurance premiums related to capital assets.

One other type of capital cost was formerly recognized under Medicare, but has not been reimbursable for hospital services since fiscal year 1989: return on equity for investor-owned hospitals. Return on equity payments provided a return to investors equivalent to what they would have earned if they had used their money for some other purpose.

Congress first distinguished between capital-related costs and other operating expenses of hospitals in 1972. Public Law 92-603 set certain limits on routine costs for inpatient care, but capital costs were excluded from those limits. Instead, Congress began an experiment with an alternative way of controlling capital expenditures: health planning. The Secretary was authorized to enter into agreements with States under which State planning agencies would review hospital proposals for construction or major equipment purchases. Medicare and Medicaid capital payments could be denied for projects undertaken without State approval.

Capital costs were again excluded when overall hospital spending limits were established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, Public Law 97-248). When the new PPS system was enacted in 1983, Congress again excluded capital costs. However, the Secretary was instructed to report to Congress on methods for including capital in PPS and was authorized (but not required) to implement prospective payment for capital on or after October 1, 1986. In addition, unless Congress acted on capital payment legislation by that date, agreements with State capital expenditure review programs would become mandatory.

The Secretary's authority to include capital in PPS was postponed twice. The Supplemental Appropriations Act of 1986 (Public Law 99-349) delayed prospective capital payment until October 1, 1987. The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) delayed prospective payment until October 1, 1991. However, the Secretary is required, not merely authorized, to implement a prospective system by that date. The system must provide for capital payments to be made on a per-discharge basis, with adjustments based on each discharge's classification under the DRGs or some similar system. At the Secretary's discretion, the system may include adjustments to reflect variations in costs of construction or borrowing, exceptions (including exceptions for hospitals with existing obligations), and adjustments to reflect hospital occupancy rates. Public Law 100-203 also eliminated Federal participation in State capital expenditure review programs.

While prospective payment for capital has been delayed, Congress has included in budget reconciliation legislation fixed percentage reductions in amounts otherwise payable by Medicare for capital costs. These cuts began in fiscal year 1987, with a 3.5 percent reduction. Medicare would compute its share of total costs for each hospital and then reduce that computed share by 3.5 percent. The percentage reduction increased to 7 percent for the first quarter of fiscal year 1988, 12 percent for the rest of that fiscal year, and 15 percent for fiscal year 1989 through fiscal year 1991. (Delays in completing budget legislation have meant that there were brief intervals in 1987 and 1989 when no reduction was taken). The reductions originally applied only to capital costs related to inpatient care. Beginning in fiscal year 1990, capital payments for outpatient hospital services were also reduced. (The reductions do not apply to certain types of rural hospitals defined in Medicare law, including sole community hospitals, essential access community hospitals, and rural primary care hospitals.)

The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) continues capital payment reductions through fiscal year 1995, with the reduction percentage lowered to 10 percent for fiscal year 1992 through 1995. Because existing law requires that some form of prospective payment begin in fiscal year 1992, the reductions will not be applied directly to each hospital's computed capital costs. Instead, the Secretary is required to set payments under the new system (or under the new system and PPS combined) in such a way as to achieve an aggregate capital spending reduction of 10 percent, as compared to what would have been spent under the current reasonable cost system.

The administration's proposed rules for prospective payment for capital costs were published in the Federal Register on February 28, 1991. After a period for public comment, final rules will be issued to take effect on October 1, 1991.

Table 6 shows the distribution of estimated total capital payments to PPS hospitals by geographic location and type of hospital for fiscal year 1991.

Table 7 shows two sets of projections of the level and the rate of increase of aggregate payments and payments per case for capital-related costs in fiscal years 1984 through 1996.

Both sets of projections for capital reflect recently enacted provisions which phase out payments for a return on equity capital for proprietary providers. The second set also includes the anticipated effects of statutory reductions in reimbursements for capital-related costs (i.e., 3.5 percent for portions of cost-reporting periods in fiscal year 1987, 12 percent for fiscal year 1988, 15 percent for fiscal year 1989 and the last three quarters of fiscal year 1990, 15 percent in fiscal year 1991, and 10 percent for fiscal years 1992–1995) enacted in the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), in the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), and in the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).

TABLE 6.—CAPITAL-RELATED PAYMENTS TO PPS HOSPITALS (INCURRED AMOUNTS FOR FISCAL YEAR 1991)

	Capital payments [1] (in millions)	PPS and capital payments [2] (in millions)	Capital payments as a percent of PPS and capital payments
All hospitals	$6,220	$59,460	10.5
Urban	5,270	50,880	10.4
Rural	940	8,580	11.0
MSA > 1 million [3]	2,900	28,370	10.2
Other urban	2,380	22,520	10.6
Rural referral	300	2,850	10.6
Rural sole community [4]	120	1,060	11.5
Other rural	520	4,670	11.1
Major teaching [5]	700	8,760	8.0
Other teaching	2,180	21,890	10.0
Nonteaching	3,330	28,820	11.6
Disproportionate share:			
MSA > 1 million	1,170	12,240	9.5
Other urban	1,120	10,860	10.3
Rural	140	1,320	10.4
Nondisproportionate share:			
MSA > 1 million	1,730	16,120	10.7
Other urban	1,260	11,660	10.8
Rural	800	7,250	11.1
New England	290	3,580	8.2
Middle Atlantic	1,020	11,560	8.8
South Atlantic	1,040	9,080	11.4
East North Central	1,070	10,390	10.3
East South Central	460	3,910	11.8
West North Central	470	4,300	10.9
West South Central	730	5,720	12.8
Mountain	300	2,520	11.7
Pacific	840	8,410	10.0

TABLE 6.—CAPITAL-RELATED PAYMENTS TO PPS HOSPITALS (INCURRED AMOUNTS FOR FISCAL YEAR 1991)—Continued

	Capital payments [1] (in millions)	PPS and capital payments [2] (in millions)	Capital payments as a percent of PPS and capital payments
Urban:			
< = 100 beds	320	2,660	12.0
101–200 beds	1,010	8,290	12.2
201–400 beds	2,330	22,130	10.5
401 + beds	1,620	17,800	9.1
Rural:			
< = 50 beds	150	1,540	9.5
51–100 beds	270	2,400	11.1
101–200 beds	340	2,820	12.2
201+ beds	190	1,820	10.2
Voluntary	4,450	43,930	10.1
Proprietary	1,050	7,460	14.0
Urban government	500	5,870	8.4
Rural government	220	2,200	10.0

[1] Capital payments are the incurred payments to hospitals covered by the prospective payment system (PPS) for capital-related expenses. For fiscal year 1991, capital payments will be equal to 85 percent of the reasonable cost of Medicare capital-related expenses for all PPS hospitals except sole community hospitals. For these hospitals, capital payments will equal 100 percent of Medicare capital-related expenses.

[2] Payments are equal to PPS payments for the operating expenses associated with providing inpatient services to Medicare beneficiaries (i.e., those payments based on diagnosis-related groups and adjusted for "disproportionate share," the indirect costs related to teaching, and other factors) plus capital payments to PPS hospitals. Payments to PPS hospitals for the direct costs of graduate medical education, and other "passthroughs" are not included. PPS payments plus capital payments equal over 95 percent of total Medicare payments to PPS hospitals for hospital inpatient services.

[3] MSA > 1 million indicates hospitals located in Metropolitan Statistical Areas with populations of more than 1 million.

[4] Sole community hospitals that are also rural referral hositals are included in the rural referral category.

[5] Major teaching hospitals are those hospitals for which the ratio of the number of full-time equivalent interns and residents to the number of beds is .25 or larger.

Source: Congressional Budget Office estimates based on data from the Health Care Financing Administration and other sources.

Physicians in teaching hospitals

If a teaching hospital so elects, the direct medical and surgical services of physicians in such hospitals will be excluded from the prospective payment system and paid for on the basis of reasonable costs.

TABLE 7.—ESTIMATED OUTLAYS FOR INPATIENT CAPITAL-RELATED COSTS UNDER MEDICARE'S HOSPITAL INSURANCE PROGRAM, FISCAL YEARS 1984–96 [1]

	Without OBRA 1986, 1987, 1989, 1990 percentage reductions		With OBRA 1986, 1987, 1989, 1990 percentage reductions [2]		
	Aggregate payments (billions)	Payments per case	Aggregate payments (billions)	Year to year percent increase	Payments per case
Fiscal year:					
1984	$3.7	$325	$3.7	NA	$325
1985	4.2	390	4.2	13.9	390
1986	4.7	450	4.7	10.9	450
1987	5.2	515	5.1	7.5	500
1988	5.9	575	5.4	6.8	525
1989	6.4	625	5.6	3.0	545
1990	7.0	660	6.1	10.1	580
1991	7.7	705	6.6	8.0	605
1992	8.5	755	7.6	15.5	680
1993	9.3	805	8.4	10.5	730
1994	10.2	860	9.3	9.6	780
1995	11.2	920	10.2	9.9	835
1996	12.3	985	12.2	19.7	975

[1] Both projections for capital-related payments reflect current law provisions which phased out payments for return-on-equity capital for proprietary providers during fiscal year 1987 through fiscal year 1989. Estimates are CBO's February 1991, projections.

[2] Includes freeze at fiscal year 1987 payment levels from Oct. 1, 1987 through Nov. 20, 1987; percentage reductions were 3.5 percent in fiscal year 1987, 12 percent in fiscal year 1988, and 15 percent in fiscal year 1989, 15 percent in the last three quarters of fiscal year 1990, 15 percent in fiscal year 1991, and 10 percent for fiscal year 1992–1995. Under current law, regulations implementing prospective payment for inpatient capital-related costs will primarily affect the distribution of payments with aggregate levels not to exceed those projected above, after they take effect on October 1, 1991.

Kidney acquisition costs

The estimated net expenses associated with kidney acquisition in certified renal transplantation centers are excluded from the prospective payment system and paid on a reasonable cost basis.

Passthrough payments for hemophilia inpatients

OBRA 1989 excludes the cost of administering blood clotting factors for hemophilia inpatients from PPS, for items furnished from June 19, 1990 through December 19, 1991. The price per unit for the blood clotting factors will be set at a predetermined rate, in consultation with ProPAC, and the cost of administering the blood clotting factors will be determined by multiplying a predetermined price per unit of blood clotting factor by the number of units provided to the individual.

ProPAC and HCFA are required to develop recommendations on how part A payments will be made for the costs of blood clotting factors and submit them to Congress by June 1991.

Bad debts of Medicare beneficiaries

An additional payment is made to hospitals for bad debts attributable to unpaid deductible and copayment amounts related to covered services received by Medicare beneficiaries.

The Secretary is prohibited from making any change in the policy in effect on August 1, 1987, including changes in hospital documentation requirements. OBRA 1989 prohibits the Secretary from requiring hospitals to change their bad debt collection policy if a fiscal intermediary accepted the policy in accordance with the rules in effect as of August 1, 1987, for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency. For such facilities, the Secretary also may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

SPECIAL TREATMENT OF CERTAIN FACILITIES

Certain exceptions and adjustments to the prospective payment rates are provided as follows:

Sole community hospitals

Sole community hospitals (SCHs) are hospitals that (because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals) are the sole source of inpatient services reasonably available in a geographic area. For cost reporting periods beginning before April 1, 1990, SCHs are paid on the same basis as all other hospitals were paid in the first year of the transition period: 25 percent of the payment is based on Federal regional DRG rates and 75 percent on each hospital's cost base.

Under the provisions of OBRA 89, the criteria for SCH designation are liberalized by allowing hospitals to be designated as such if they are located more than 35 road miles from another hospital. In addition, OBRA 89 provides the Secretary with the authority to designate a hospital as an SCH if, by reason of factors such as travel time to the nearest alternative source of appropriate inpatient care, location, weather conditions, travel conditions, or absence of other like hospitals, the Secretary determines that it is the sole source of inpatient hospital services reasonably available to individuals in a geographic area.

In addition, OBRA 1989 established new payment provisions that apply to all SCHs for cost reporting periods beginning after April 1, 1990. An SCH may receive the higher of the following rates as the basis of reimbursement: a target amount based on 100 percent hospital-specific prospective rates based on fiscal year 1982 costs updated to the present; a target amount based on hospital-specific prospective rates based on fiscal year 1987 costs updated to the present; or the Federal PPS rate. Current SCHs not meeting the new criteria are allowed to continue to qualify for payments as an SCH.

OBRA 1989 makes permanent the provision by which an SCH may request additional payments if the hospital experiences a decrease of more than 5 percent in its total inpatient cases due to circumstances beyond its control. An SCH may receive such payments if it meets sole community hospital criteria but is not being paid as a sole community hospital. As of September 1989, 409 hospitals were classified as sole community providers.

Medicare dependent hospitals

OBRA 1989 created a new classification of hospitals termed Medicare dependent hospitals. Medicare dependent hospitals are hospitals that are located in a rural area, have 100 beds or less, are not classified as a sole community provider, and for which not less than 60 percent of inpatient days or discharges in the hospital cost reporting period that began during fiscal year 1987 were attributable to Medicare. These hospitals are reimbursed in the same fashion as sole community providers. As of September 1990, there are 557 Medicare dependent hospitals.

Referral centers

The Secretary is authorized to provide exceptions and adjustments as appropriate for regional and national referral centers. These centers are defined as:

(1) rural hospitals having 275 or more beds;

(2) hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries are furnished to those who live 25 miles or more from the hospital; or

(3) rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985:

(a) a case mix index equal to or greater than the median case mix for all urban hospitals (the national standard), or the median case mix for urban hospitals located in the same census region, excluding hospitals with approved teaching programs. (The case mix index is a measure of the relative costliness of the hospital's mixture of cases among the DRGs compared to the national average mixture of medicare cases);

(b) a minimum of 5,000 discharges, the national discharge criterion (3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and

(c) at least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

Referral centers are paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as adjusted by the hospital's area wage index. The applicable amount is the "other urban" rate (i.e., the rate for urban areas with 1 million or fewer people) for all referral centers except those (if any) located in MSAs greater than 1 million.)

Under the regulations, once a hospital has achieved referral center status, it is paid at the applicable urban rate for a 3-year period. Public Law 99-509 permitted hospitals designated as regional referral centers, as of the date of enactment, to continue their designation through cost reporting periods beginning before October 1, 1989. OBRA 89 extends the status of current referral centers for three additional years, including all hospitals classified as referral centers as of September 30, 1989. As of September 1989, 244 hospitals were qualified as referral centers.

Hospitals in rural counties treated as urban counties

Hospitals in areas that are reclassified from urban to rural under OMB's MSA system are allowed a 2-year transition period during which they are paid a blend of the applicable urban and rural rates.

Public Law 100-203 provided for the reclassification of rural hospitals as urban if the county in which the hospital was located was adjacent to two or more MSAs and met criteria regarding commuting patterns of its residents to the central counties of the adjacent MSAs. If treating a hospital located in a rural county as being located in an urban area reduced the wage index for that urban area or for other rural areas in the State, Public Law 100-647 required an adjustment to ensure that, for discharges during fiscal year 1990 and 1991, no other area suffered a reduced wage index.

Public Law 101-239 (OBRA 1989) allows hospitals to apply for reclassification from rural to urban and allows counties to apply for reclassification from rural to urban. In addition, OBRA 1989 establishes a floor for area wage indices so that the reclassification of hospitals under the new procedures or the rules enacted in OBRA 1987 cannot result in the reduction of a county's wage index below the wage index for other rural areas within the same State.

Public Law 101-239, requires the Secretary to establish a Geographic Classification Review Board to consider appeals by hospitals for a change in classification from rural to urban, or from one urban area to another urban area.

The Act also revises the rules for the adjustment of wage indices required as a result of the reclassification of hospitals under the OBRA 1987 provision or under the new procedures for reclassification. If reclassification of a county into an urban area reduces the wage index for that area by 1 percent or less, then the MSA wage index applies to hospitals in the reclassified county, but the reclassified county is to be excluded from the computation of the index. If the reclassification reduces the urban area's wage index by more than 1 percent, separate wage indices are to be computed for the original urban area and for the reclassified county. If the reclassification of a rural county results in a reduction in the wage index for the other rural counties in the State, the index is to be computed as if the reclassification had not occured. Finally, no reclassification can reduce any area's wage index to a level below the index for rural areas in the State. The new rules are effective April 1, 1990.

OBRA 1990 provides that if including wages of all redesignated hospitals in the wage index of the MSA to which they are redesignated reduces the MSA's wage index by more than 1 percentage point, then the original wage index (calculated without the wages of the redesignated hospitals) is applied to hospitals in the MSA. Redesignated hositals would receive a wage index combining their wages plus the wages of the MSA to which they were redesignated. OBRA 1990 also extends the due date for initial applications for reclassification submitted to the Geographic Classification Review Board until November 6, 1990, and clarifies the Secretary's ability to review decisions of the Board.

Section 602k hospitals

Prior to Public Law 98-21, payments for nonphysician services (in such areas as radiology, laboratory, physical therapy, prosthetics) provided to Medicare beneficiaries who were hospital inpatients were made either (1) to the hospital under part A of Medicare on a reasonable cost basis or (2) to an outside supplier of the service under part B of Medicare on the basis of reasonable charges. The practice of billing under part B for services provided to hospital inpatients is known as the "unbundling" of part A services.

Public Law 98-21 provided that, effective October 1, 1983, for all hospitals participating in the Medicare program (including those under prospective payment, excluded hospitals, and those paid under State cost control systems), all nonphysician services provided to hospital inpatients will be paid only as hospital services under the part A program. The Secretary has authority to waive this requirement during the transition period to allow billing under part B for hospitals that had such extensive billings under part B prior to October 1, 1982, that compliance with the new requirement would threaten the stability of patient care (commonly referred to as 602k hospitals). As of December 1985, there were four 602k hospitals.

HOSPITALS EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM

The following hospitals are by law excluded from the prospective payment system and are paid on the basis of reasonable costs, subject to the TEFRA rate of increase limits: psychiatric hospitals, rehabilitation hospitals, psychiatric or rehabilitation units which are distinct parts of a hospital, alcohol and drug abuse hospitals and such distinct units of hospitals (for cost reporting periods beginning before October 1, 1987), children's hospitals (with patients averaging under 18 years of age), long-term hospitals (with an average inpatient length of stay greater than 25 days), and hospitals outside the 50 States and the District of Columbia. Public Law 99-509 provided that hospitals located in Puerto Rico will be included in PPS, specially adjusted for Puerto Rico, effective with discharges occurring on or after October 1, 1987. Public Law 101-239 exempts cancer hospitals (hospitals extensively involved in treatment for and research on cancer) classified as such before December 31, 1990, from PPS. In addition, the act provides an exemption for any hospital classified as a cancer hospital before December 31, 1991, that is located in a State that has a PPS waiver under section 1814(b) (i.e., Maryland). In addition, there are special cases where the prospective payment system is not applied, such as for emergency services provided to Medicare beneficiaries in hospitals not participating in Medicare and Veterans' Administration hospital services provided to Medicare beneficiaries.

Hospitals reimbursed under approved State cost control systems are also excluded from the prospective rates.

Section 1886(c) of the Social Security Act (as added by TEFRA) gave the HHS Secretary discretion to reimburse hospitals in a State according to the State's hospital reimbursement control system rather than according to Medicare's reimbursement methods if the State requests this change and if HHS determines that the State system meets certain requirements. Currently one State has a waiver to operate its own system: Maryland. New York has a waiver convering four counties participating in the Finger Lakes Area Hospital Corporation (FLAHC) rural hospital payment demonstration.

Public Laws 98-21 and 98-369 added several more requirements for State systems. According to final regulations published by HHS on April 24, 1986 (51 F.R. 15481), implementing these legislative changes, HHS has the discretion to allow Medicare hospital reimbursement to be made in accordance with a State reimbursement control system if the chief executive officer of the State requests approval of the State system, and provided that the State system:

(a) Applies to substantially all non-federal acute care hospitals in the State.

(b) Applies to at least 75 percent of all inpatient revenues or expenses for the State.

(c) Provides assurances that payers, hospital employees and patients in the State will be treated equitably under its system.

(d) Provides assurances that its system will not result in greater Medicare expenditures over 36-month periods.

(e) Does not preclude health maintenance organizations (HMOs) or competitive medical plans (CMPs) from negotiating directly with hospitals concerning payment for inpatient services.

(f) Limits hospital charges to Medicare beneficiaries to deductibles, coinsurance, and services for which the beneficiary would not be entitled to have payment made under Medicare Part A; and prohibits payment under Part B of Medicare for nonphysician services provided to hospital inpatients unless this prohibition is waived.

Public Law 101-239 (OBRA 1989) requires the Secretary's test of effectiveness of a State cost containment system to be based on the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available. This provision extends the waiver for the FLAHC rural hospital payment demonstration.

Special provisions apply to States that have existing demonstration projects approved by HCFA under section 402 of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendment of 1972 for the operation of State reimbursement control systems. HHS approval of a State's application to continue the operation of a system upon expiration of the demonstration project is mandatory if, and for so long as, the system meets the minimum requirements described in items (a) through (f) above.

Public Law 101-508 revises the Secretary's test of effectiveness of a State cost containment system to be based on the rate of increase in costs per hospital inpatient admission as compared to the rate of increase in such costs with respect to all hospitals between January 1, 1981, and the present. In addition, OBRA 1990 provides that a State no longer qualifying for a PPS waiver be provided with a reasonable period, not to exceed two years, for transition from the State system to the national payment system, and requires restoration of the waiver if the State returns to compliance during the transition period.

ADMINISTRATION

Prospective Payment Assessment Commission

Public Law 98-21 required the Director of the Congressional Office of Technology Assessment (OTA) to appoint by April 1, 1984, a commission of 15 independent experts, known as the Prospective Payment Assessment Commission (ProPAC). Public Law 99-272 added two members to ProPAC, bringing the total to 17 members.

The Commission must: (1) consult with and make recommendations to the Secretary on the need for adjustments to the DRG classifications, the methodology for classifying specific hospital discharges within the DRGs, and weighting factors for the DRGs; [3] and (2) report to Congress its evaluation of any adjustments which the Secretary makes.[4]

Each year, ProPAC also submits a report to Congress which provides background information on trends in health care delivery and financing, including the impact of the prospective payment system on providers and beneficiaries. Prior to 1988, this report to Congress was submitted in February each year. Because the Commission's report and recommendations to the Secretary is due earlier, however, the report to Congress has been rescheduled for June 1, each year.[5]

OBRA 1990 expands ProPAC's responsibilities for studying hospital payment policies under PPS, requiring the Commission to advise the Congress, in addition to the Secretary. The Secretary is required to submit to Congress recommendations that take into account ProPAC's recommendations, and include a written explanation of those recommendations that differ from those of the Commission.

Public Law 101-508 requires ProPAC to study and make recommendations for each fiscal year on Medicare's reimbursement of nonhospital institutional services. In addition, ProPAC is required to include in the June 1 report to Congress an examination of issues affecting health care delivery.

---

[3] See Prospective Payment Assessment Commission. Report and Recommendation to the Secretary, U.S. Department of Health and Human Services, March 1, 1991.

[4] See Prospective Payment Assessment Commission, 1990 Adjustments to the Medicare Prospective Payment System. Report to Congress, November 1989.

[5] See Prospective Payment Assessment Commission, Medicare Prospective Payment and the American Health Care System. Report to Congress, June 1989.

Administrative and judicial review

Administrative and judicial appeals are allowed under procedures and authorities already established under the Medicare program. However, the law precludes administrative and judicial review of: (1) the "budget neutrality" adjustment (see above), and (2) the DRG payment amounts, including the establishment of DRGs, the methodology for classifying discharges within DRGs, and the DRG weighting factors.

Review activities

Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (known as TEFRA) replaced the existing Professional Standards Review Organization (PSRO) program with the utilization and quality control peer review program. The Secretary of the Department of Health and Human Services was required to enter into performance-based contracts with physician-sponsored or physician-access organizations known as Peer Review Organizations (PRO's) by November 15, 1984. As a condition of receiving payments under the prospective payment system, hospitals are required to enter into an agreement with a PRO under which the PRO will review the validity of diagnostic and procedural information provided by the hospitals; the completeness, adequacy and quality of care provided; and the appropriateness of admissions patterns, discharges, lengths of stay, transfers, and services furnished in outlier cases.

Since 1982, the statute governing the PRO program has been amended numerous times, and the PROs are now operating under the third "scope of work." In addition to reviewing inpatient care and some ambulatory care services, the PROs are now required to review hospital readmissions within 31 days of a previous hospital discharge to determine if the previous inpatient services and the posthospital services met professionally recognized standards of care. This provision was enacted as part of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), partly in response to congressional concerns that the prospective payment system was encouraging hospitals to discharge patients prematurely to inappropriate levels of care.

HISTORICAL TRENDS IN PPS PAYMENTS AND HOSPITAL MEDICARE COST, REVENUE, AND UTILIZATION

Trends in PPS costs, revenue, and margins

In the following tables, PPS1, PPS2, PPS3, PPS4, and PPS5 indicate the first through fifth years of the prospective payment system, respectively. Hospitals were phased into the prospective payment system beginning October 1, 1983, depending on when the hospital's accounting or fiscal year began. Thus, PPS1 is the first year of prospective payment for each individual hospital and generally covers Federal fiscal years 1984 and 1985.

Following an increase of only 2.1 percent in the first year of PPS, PPS operating costs per case rose about 10 percent per year during the second through fifth years—more than 5 percentage points per year above the PPS market basket (see table 8). PPS payment per case increases were substantial during the first 2 years of PPS, but were dramatically lower in the next 3 years. In each year, per case payment increases were greater than the PPS market basket. PPS payments have also grown faster than the update factor, primarily because of the increased frequency of higher-weighted DRGs.

The cumulative increases in costs and payments per case in the first 5 years of PPS are 49.8 percent and 49.2 percent, respectively (see chart 1). Total PPS costs and payments increased far less than costs and payments per case during the first five years of PPS because Medicare admissions were declining during that period.

The aggregate PPS margin was above 14 percent in the first 2 years of PPS, falling to 10.1 percent in the third year, 5.7 percent in the fourth year and 2.6 percent in the fifth year (see table 9). PPS margins are defined as PPS payments less PPS operating costs divided by PPS payments. More than half of all hospitals incurred losses under PPS during the fifth year (see table 10).

PPS margins do not represent the bottom line for the hospital industry. Total margins, which include expenses and revenues related to other payers, increased steadily from the early 1970s to the early 1980s, peaking in 1984. Data from the American Hospital Association's National Hospital Panel Survey indicate that, after a slight decline, the total margin has leveled off. The total margin in 1989, 5.0 percent, is comparable to pre-PPS levels.

TABLE 8.—PERCENT CHANGE IN PPS OPERATING COSTS, PAYMENTS, AND CASES, PPS5

[In percent]

Year [1]	Operating costs	Payments	Cases	Operating costs per case	Payments per case	Market basket	Update factor
PPS1	−4.8	11.0	−6.7	2.1	18.9	4.9	4.7
PPS2	4.1	4.0	−5.7	10.4	10.3	4.0	4.5
PPS3	5.9	−0.3	−3.6	9.8	3.4	3.1	0.5
PPS4	9.0	3.7	−0.7	9.8	4.5	3.5	1.2
PPS5	11.0	6.5	0.9	9.9	5.8	4.8	1.5
Cumulative effect:							
PPS1				2.1	18.9	4.9	4.7
PPS2				12.7	31.1	9.1	9.4
PPS3				23.7	35.6	12.5	10.0
PPS4				35.8	41.6	16.4	11.2
PPS5				49.2	49.8	22.0	12.9

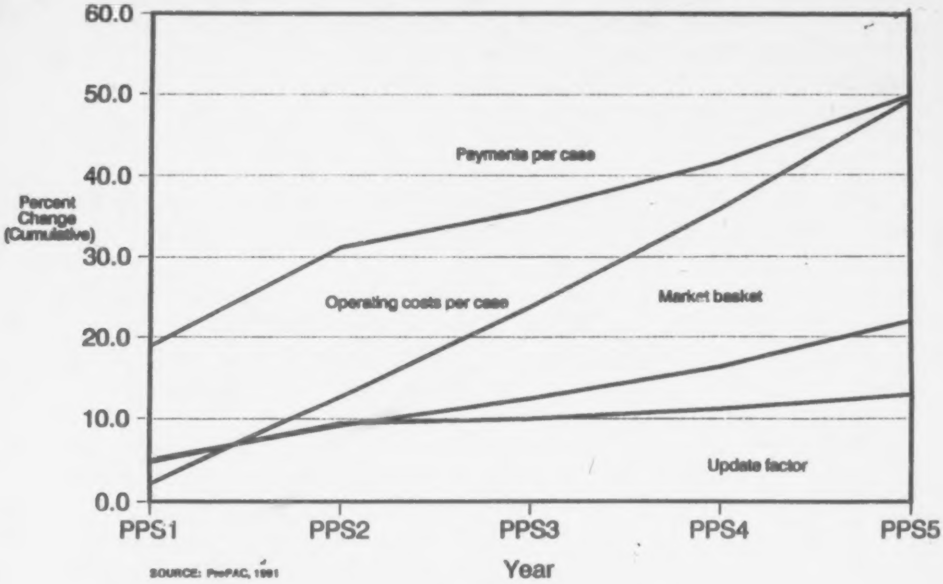
---

[1] Data on costs, payments, and cases are for hospital accounting years beginning during each Federal fiscal year. Data on the market basket and update factor are from the corresponding Federal fiscal year (1984 for PPS1, etc.).

Note: Hospitals in Maryland, Massachusetts, New Jersey, and New York excluded from PPS1 and PPS2. Hospitals in Maryland and New Jersey also excluded from PPS3 through PPS5. Data based on cohorts of hospitals with cost reports available in each of 2 successive years.

Source: ProPAC analysis of Medicare cost report data from the Health Care Financing Administration.

CHART 1. CUMULATIVE PPS COST AND PAYMENT TRENDS, FIRST 5 YEARS



SOURCE: ProPAC, 1991

TABLE 9.—AGGREGATE PPS PAYMENTS AND COSTS PER CASE AND PPS OPERATING MARGINS FOR THE FIRST 5 YEARS OF PPS

	PPS1	PPS2	PPS3	PPS4	PPS5
PPS payments per case	$3,522	$3,913	$4,086	$4,273	$4,415
PPS operating costs per case	3,010	3,348	3,679	4,033	4,298
PPS operating margin:					
All hospitals (percent)	14.5	14.4	10.1	5.7	2.6
Urban hospitals	15.8	15.5	11.3	6.8	3.6
Rural hospitals	8.4	8.8	3.1	−0.3	−2.3

Note: Hospitals in Maryland, Massachusetts, New Jersey, and New York excluded from PPS1 and PPS2. Hospitals in Maryland and New Jersey also excluded from PPS3 through PPS5.

Source: ProPAC analysis of Medicare cost report data from the Health Care Financing Administration.

Margins by hospital type.—PPS margins vary by hospital type (see table 11). During the first 4 years of PPS, urban hospitals had substantially higher margins than rural hospitals. Within both categories, margins increased with bed size. The urban/rural margin differential is likely to have decreased, because policy changes in recent years have increased payments to rural hospitals relative to urban hospitals. Major teaching hospitals and large urban hospitals with disproportionate shares of poor patients had relatively high margins during the first 5 years of PPS.

TABLE 10.—PERCENTILE DISTRIBUTION OF PPS OPERATING MARGINS AND PERCENT OF HOSPITALS WITH NEGATIVE MARGINS FOR THE FIRST 5 YEARS OF PPS

	PPS1	PPS2	PPS3	PPS4	PPS5
10th percentile	−6.7	−8.4	−17.2	−23.1	−28.3
25th percentile	3.4	2.2	−3.8	−8.5	−12.2
Median	11.3	10.7	5.7	2.1	−0.5
75th percentile	17.7	17.9	13.6	11.0	9.8
90th percentile	23.2	24.2	20.2	18.7	18.6
Percent with negative margin	18.0	20.0	33.5	44.1	51.2

Note: Hospitals in Maryland, Massachusetts, New Jersey, and New York excluded from PPS1 and PPS2. Hospitals in Maryland and New Jersey also excluded from PPS3 through PPS5.

Source: ProPAC analysis of Medicare cost report data from the Health Care Financing Administration.

TABLE 11.—COMPARISON OF PPS OPERATING MARGINS FOR THE FIRST 5 YEARS OF PPS, BY HOSPITAL GROUP

[In percent]

Hospital group	PPS1	PPS2	PPS3	PPS4	PPS5
All hospitals	14.5	14.4	10.1	5.7	2.6
Urban	15.8	15.5	11.3	6.8	3.6
Rural	8.4	8.8	3.1	−0.3	−2.3
Large urban	16.2	15.3	11.7	6.7	3.6
Other urban	15.2	15.7	10.6	6.8	3.5
Rural referral	9.5	13.4	8.2	4.3	−0.1
Sole community	6.9	6.2	1.2	−2.7	−4.2
Other rural	8.0	6.5	0.3	−2.8	−3.4
Major teaching	19.0	21.0	18.2	14.9	15.1
Other teaching	16.4	16.1	11.7	7.0	3.9
Non-teaching	12.2	11.5	6.3	1.9	−1.7
Disproportionate share:					
Large urban	17.0	16.1	14.3	10.3	8.8
Other urban	14.9	16.0	11.6	8.7	6.3
Rural	10.4	10.8	5.3	2.4	−0.5
Non-disproportionate share	13.9	13.6	8.3	3.2	−0.2
New England	13.1	12.3	9.5	5.7	−1.6
Middle Atlantic	16.7	16.8	15.1	12.3	9.5
South Atlantic	13.2	12.7	6.7	1.8	−2.9
East North Central	14.0	15.1	10.3	5.3	2.3
East South Central	11.0	12.2	5.9	2.6	2.3
West North Central	16.7	16.3	11.5	7.0	3.8
West South Central	15.8	14.5	9.1	3.2	−0.5
Mountain	13.6	16.1	11.5	6.7	2.3
Pacific	15.5	14.0	9.3	5.2	3.3
Urban <100 beds	13.3	12.4	6.3	1.6	−2.2
Urban 100–249 beds	14.5	13.2	8.8	4.3	−0.2
Urban 250–404 beds	15.6	15.0	10.8	6.0	2.1
Urban 405–684 beds	16.1	17.2	12.9	7.5	6.2

TABLE 11.—COMPARISON OF PPS OPERATING MARGINS FOR THE FIRST 5 YEARS OF PPS, BY HOSPITAL GROUP—Continued

[In percent]

Hospital group	PPS1	PPS2	PPS3	PPS4	PPS5
Urban 685+ beds	21.0	20.4	17.0	14.6	12.5
Rural <50 beds	6.4	6.0	−0.9	−2.3	−3.5
Rural 50–99 beds	8.4	7.4	1.4	−1.6	−4.0
Rural 100–169 beds	8.8	8.1	3.0	−0.7	−0.5
Rural 170+ beds	9.4	12.4	6.9	2.4	−1.8
Voluntary	15.0	15.1	10.9	6.5	3.3
Proprietary	14.1	12.7	7.6	2.0	−1.6
Urban government	15.1	14.8	9.9	8.6	6.0
Rural government	7.0	6.1	−0.1	−3.6	−1.5

Note: Data for each PPS year (PPS 1, PPS 2, etc.) correspond to each hospital's cost reporting period beginning in that year. For instance, the PPS 1 year includes data from each hospital's cost report beginning during the first year of PPS (Federal fiscal year 1984). Excludes hospitals in Maryland and New Jersey; includes hospitals in Massachusetts and New York, beginning with PPS 3.

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Distribution of PPS hospitals, cases, and payments

Tables 12 through 15 show the distribution of PPS hospitals, cases, and PPS payments.

Medicare passthrough payments

Tables 12 and 13 show the distribution of PPS hospitals, cases, and PPS payments. During the fifth year of PPS, 13 percent of all hospital payments were payments for capital and direct medical education expenses. These payments are frequently referred to as passthrough payments because at the beginning of PPS, they were paid on a cost reimbursement basis, or passed through, to Medicare. The hospitals with the highest proportion of passthrough payments were predominantly large, teaching and located in urban areas (see table 14). In contrast, hospitals with the lowest passthrough payments tended to be small and located in rural areas.

TABLE 12.—DISTRIBUTION OF PPS HOSPITALS AND DISCHARGES AND ESTIMATED FISCAL YEAR 1990 PPS PAYMENTS, BY HOSPITAL GROUP

[In percent]

Hospital group	PPS hospitals	PPS discharges	Total PPS payments	Indirect teaching payments	Disproportions share payments	Outier payments
All hospitals	100	100	100	100	100	100
Urban	53	77	85	98	95	94
Rural	47	23	15	2	5	6
Large urban	26	40	47	67	57	58

TABLE 12.—DISTRIBUTION OF PPS HOSPITALS AND DISCHARGES AND ESTIMATED FISCAL YEAR 1990 PPS PAYMENTS, BY HOSPITAL GROUP—Continued

[In percent]

Hospital group	PPS hospitals	PPS discharges	Total PPS payments	Indirect teaching payments	Disproportions share payments	Outier payments
Other urban	26	38	38	31	37	36
Rural referral	4	7	5	2	2	3
Sole community	5	2	1	(1)	(1)	(1)
Other rural	38	14	9	(1)	3	3
Major teaching	4	9	15	60	32	25
Other teaching	16	33	37	40	35	41
Non-teaching	80	58	48	0	33	34
Disproportionate share:						
Large urban	10	15	21	43	57	31
Other urban	11	18	19	21	37	20
Rural	7	4	3	1	5	1
Non-disproportionate share	72	63	57	35	0	47
Urban <100 beds	14	6	5	1	2	3
Urban 100–249 beds	19	21	20	8	23	16
Urban 250–404 beds	11	24	26	23	28	28
Urban 405–684 beds	6	19	23	41	28	31
Urban 685+ beds	2	7	10	26	13	16
Rural <50 beds	23	5	3	(1)	(1)	(1)
Rural 50–99 beds	14	6	4	(1)	1	1
Rural 100–169 beds	7	6	4	(1)	2	1
Rural 170+ beds	4	6	5	1	3	3
New England	4	6	6	10	3	8
Middle Atlantic	9	14	17	29	23	26
South Atlantic	14	17	15	11	16	16
East North Central	15	18	18	22	12	15
East South Central	9	8	7	3	8	5
West North Central	14	8	8	7	3	5
West South Central	15	11	10	5	11	9
Mountain	7	4	4	3	2	3
Pacific	12	12	15	10	21	12
Voluntary	54	70	73	77	63	75
Proprietary	20	14	13	2	11	10
Urban government	7	8	10	18	22	13
Rural government	16	6	4	(1)	1	1

[1] Less than 0.5 percent.

Note: PPS payments estimated using PPS rules in effect as of April 1, 1990. Excludes hospitals in Maryland and New Jersey. Columbus may not add to 100 due to rounding.

Source: ProPAC estimates based on ProPAC PPS payment modest and fiscal year 1988 MedPAR file data from the Health Care Financing Administration.

TABLE 13.—DISTRIBUTION OF ESTIMATED FISCAL YEAR 1990 PPS PAYMENTS, BY PAYMENT TYPE AND HOSPITAL GROUP

[In percent]

Hospital group	Basic DRG payments	Indirect teaching payments	Disproportionate share payments	Outlier payments
All hospitals	86.2	5.3	3.3	5.2
Urban	84.4	6.2	3.7	5.8
Rural	96.3	0.6	1.1	1.9
Large urban	82.1	7.6	4.0	6.3
Other urban	87.3	4.4	3.3	5.0
Rural referral	94.2	1.7	1.1	3.0
Sole community	99.1	([1])	0.7	0.2
Other rural	97.2	0.1	1.2	1.5
Major teaching	63.6	21.0	6.9	8.5
Other teaching	85.2	5.8	3.1	5.8
Non-teaching	94.1	0.0	2.3	3.7
Disproportionate share:				
Large urban	72.7	10.8	8.9	7.6
Other urban	81.8	6.0	6.5	5.6
Rural	89.4	1.1	6.8	2.7
Non-disproportionate share	92.5	3.3	0.0	4.2
Urban < 100 beds	95.3	0.7	1.1	2.9
Urban 100–249 beds	90.0	2.1	3.7	4.1
Urban 250–404 beds	86.1	4.8	3.6	5.5
Urban 405–684 beds	79.9	9.2	4.0	6.9
Urban 685+ beds	73.0	14.1	4.4	8.5
Rural < 50 beds	98.8	0.1	0.4	0.7
Rural 50–99 beds	98.1	0.4	0.5	1.0
Rural 100–169 beds	96.5	0.1	1.5	1.9
Rural 170+	93.1	1.6	1.8	3.5
New England	82.7	8.6	1.7	7.0
Middle Atlantic	78.1	9.2	4.6	8.2
South Atlantic	87.2	3.9	3.3	5.5
East North Central	87.3	6.4	2.2	4.1
East South Central	89.3	2.6	4.1	3.9
West North Central	90.5	4.7	1.5	3.3
West South Central	88.6	2.8	3.8	4.8
Mountain	91.7	3.4	1.4	3.5
Pacific	87.4	3.7	4.6	4.4
Voluntary	86.2	5.6	2.9	5.3
Proprietary	92.3	0.8	2.9	4.0
Urban government	75.8	10.1	7.3	6.7
Rural government	96.8	0.4	1.2	1.6

[1] Less than 0.05 percent.

Note: PPS payments estimated using PPS rules in effect as of April 1, 1990. Excludes hospitals in Maryland and New Jersey. Rows may not add to 100 due to rounding.

Source: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1988 MedPAR file data from the Health Care Financing Administration.

TABLE 14.—MEDICARE PASSTHROUGH PAYMENTS AS A PERCENTAGE OF TOTAL MEDICARE INPATIENT HOSPITAL PAYMENTS IN THE FIFTH YEAR OF PPS, BY HOSPITAL GROUP

[In percent]

Hospital group	Capital payments	Direct medical education payments	Combined total
All hospitals	10.1	2.9	13.0
Urban	10.0	3.3	13.2
Rural	11.0	0.4	11.4
Large urban	9.8	4.2	14.0
Other urban	10.1	2.2	12.2
Rural referral	10.7	1.0	11.7
Sole community	11.0	0.2	11.2
Other rural	11.2	0.1	11.2
Major teaching	7.4	9.3	16.7
Other teaching	9.3	3.8	13.1
Non-teaching	11.5	0.2	11.7
Disproportionate share:			
Large urban	9.2	6.1	15.3
Other urban	9.9	2.4	12.3
Rural	11.0	0.8	11.8
Non-disproportionate share	10.4	2.0	12.4
Urban < 100 beds	11.3	0.3	11.6
Urban 100–249 beds	11.7	1.1	12.8
urban 250–404 beds	10.0	2.8	12.7
Urban 405–684 beds	8.9	4.7	13.6
Urban 685+ beds	8.0	7.5	15.5
Rural < 50 beds	10.3	0.1	10.4
Rural 50–99 beds	11.6	0.1	11.7
Rural 100–169 beds	11.4	0.2	11.6
Rural 170+ beds	10.5	1.1	11.6
Voluntary	9.8	3.2	13.0
Proprietary	13.4	0.5	13.9
Urban government	8.4	3.8	12.2
Rural government	10.4	0.5	10.8

Note: Total passthrough payments also include organ acquisition payments and other Medicare inpatient hospital not paid under PPS. Only capital and direct medical education payments are included in this table. Excludes hospitals in Maryland and New Jersey.

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

TABLE 15.—ESTIMATED PPS PAYMENTS [1] TO HOSPITALS, BY PAYMENT TYPE

[Dollar amounts in billions]

	1991 percent	Final year—					
		1990	1991	1992	1993	1994	1995
Gross PPS payments	100.0	$53.2	$57.4	$61.7	$67.7	$74.1	$80.3
Indirect teaching	5.4	2.9	3.1	3.3	3.7	4.0	4.4
Disproportionate share	4.1	2.2	2.3	2.5	2.8	3.0	3.3
Outlier [2]	4.9	2.6	2.8	3.0	3.3	3.6	3.9
Less copayments		−5.4	−5.8	−6.2	−6.7	−7.2	−7.8
Net payment from Medicare		47.8	51.6	55.6	61.1	66.9	72.5

[1] Estimated incurred PPS payments. Includes the effects of the Omnibus Reconciliation Act of 1990.

[2] Outlier payments due to the indirect medical education adjustment are included in the indirect teaching payments; outlier payments due to the disproportionate share adjustment are included in disproportionate share payments.

Source: CBO.

Effects of policy changes on PPS payments

Since the implementation of PPS, the distribution of Medicare payments to hospitals has changed. Some redistribution has resulted from changes in hospital behavior, but much of it is attributable to policy decisions. These include the transition to national average rates, reductions in teaching hospital payments, the addition of a disproportionate share adjustment, and separate update factors for rural hospitals, hospitals in large urban areas, and other urban hospitals.

The update factor and other policy decisions implemented between fiscal years 1984 and 1990 increased per-case PPS payment rates by 18.3 percent (see table 16). These policy decisions have redistributed PPS payments toward rural hospitals, particularly for sole community hospitals. Smaller hospitals and nonteaching hospitals have also benefited from policy changes. Alternatively, larger hospitals and major teaching hospitals received relatively small per-case payment rate increases.

The Medicare case-mix index (CMI) reflects the mix of each hospital's cases across DRGs. Because hospitals are paid on this basis, an increase in the CMI results in a proportional increase in PPS payments. CMI changes have, in some instances, partially offset the intended effects of policy decisions. For example, with case mix change included, payments for urban hospitals grew almost as fast as payments for rural hospitals. Payments to major teaching hospitals grew faster than those to nonteaching hospitals, also due to CMI change.

TABLE 16.—EFFECTS OF PPS UPDATE FACTOR AND OTHER PAYMENT POLICY CHANGES IN PER-CASE PPS PAYMENT RATE, BY HOSPITAL GROUP

[In Percent]

Hospital group	Fiscal year—						Total	Including Effect of Change in Case Mix[1]
	1985	1986	1987	1988	1989	1990		
All hospitals	5.4	1.0	0.8	3.4	2.4	4.2	18.3	42.6
Urban	5.2	1.0	0.4	2.9	2.4	3.7	16.5	41.7
Rural	6.2	0.9	3.1	6.2	2.8	7.1	29.2	48.1
Large Urban	3.9	0.9	−0.6	2.2	2.4	3.9	13.2	37.3
Other urban	6.8	1.2	1.6	3.8	2.3	3.6	20.8	47.4
Rural referral	8.5	1.4	2.8	5.0	1.7	4.5	26.3	50.4
Sole community	4.5	0.4	1.8	4.0	3.5	18.3	36.0	52.4
Other rural	5.2	0.7	3.4	7.3	3.4	7.1	30.2	45.9
Major teaching	5.7	−1.5	0.5	2.4	4.4	4.7	17.1	46.5
Other teaching	5.1	0.7	0.0	2.1	2.4	3.5	14.4	39.2
Non-teaching	5.5	1.8	1.5	4.7	1.9	4.7	21.6	43.9
Disproportionate share:								
Large urban	3.1	1.5	−0.1	3.2	2.7	4.6	15.8	41.0
Other urban	6.8	1.8	2.2	4.7	2.7	3.9	23.9	51.7
Rural	6.3	0.4	3.6	7.7	3.5	10.4	36.1	57.1
Non-disproportionate share	5.6	0.7	0.5	2.9	2.2	4.0	16.8	39.9
Urban < 100 beds	6.5	2.5	1.8	4.1	2.0	3.9	22.6	44.3
Urban 100–249 beds	5.2	2.4	1.2	4.3	1.5	3.5	19.4	42.3
Urban 250–404 beds	5.0	1.3	0.2	2.6	2.2	3.8	15.8	40.6
Urban 405–684 beds	5.0	0.1	−0.2	2.3	2.8	3.8	14.4	41.0
Urban 685+ beds	5.2	−1.6	−0.2	1.6	3.8	3.8	13.0	40.2
Rural < 50 beds	6.3	1.4	3.6	7.2	3.7	8.8	34.9	46.4
Rural 50–99 beds	5.4	0.3	3.5	7.1	3.4	7.8	30.4	45.5
Rural 100–169 beds	4.9	1.4	2.5	5.7	2.5	7.2	26.7	47.6
Rural 170+ beds	8.1	0.8	2.9	5.4	2.2	5.4	27.2	50.5
New England	6.1	0.9	0.6	1.5	2.5	3.9	16.4	39.1
Middle Atlantic	6.2	−0.7	2.1	6.5	0.8	3.7	19.9	44.9
South Atlantic	7.2	0.7	1.8	5.0	2.0	4.8	23.2	50.1
East North Central	5.3	0.4	−0.3	−0.7	2.6	3.0	10.6	31.1
East South Central	5.9	0.7	2.1	7.3	1.9	5.3	25.3	48.4
West North Central	4.6	0.3	0.6	2.4	3.7	4.7	17.3	41.9
West South Central	4.9	0.7	1.1	3.6	3.4	4.7	19.8	47.6
Mountain	5.5	0.4	1.3	4.0	3.5	5.6	21.8	44.0
Pacific	3.5	4.0	−1.0	2.9	3.1	4.6	18.3	42.2
Voluntary	5.2	0.9	0.3	2.5	2.5	3.9	16.2	39.6
Proprietary	5.2	1.2	1.5	6.2	0.8	4.9	21.2	49.3
Urban government	6.9	1.6	2.4	5.1	3.3	4.7	26.4	53.1
Rural government	6.3	0.8	3.7	6.9	3.1	7.3	31.3	48.6

---

[1] The effect of change in case mix for 1989 and 1990 is estimated from the average annual effect for 1985 through 1988.

Note: Figures are not estimates of actual changes in fiscal year PPS hospital payments. They are meant to isolate the effects of changes in PPS rules on PPS payment rates, holding all other factors constant. Payments for each year are estimated based on the PPS rules in effect on the last day of the fiscal year. The effect of change in case mix is reflected only in the last column. Excludes hospitals in Maryland and New Jersey; includes hospitals in Massachusetts and New York, beginning with fiscal year 1987.

Source: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1988 MedPAR file data from the Health Care Financing Administration.

Table 17 provides historical data on recent trends in some of the factors related to increases in the PPS payment rates and increases in average payments per Medicare discharge. Trends in the general level of prices of goods and services as measured by the GNP deflator are also shown for comparison.

The actual increase in the PPS payment rates (the DRG prices) has differed from the update factor each year for several reasons. For example, in the first 2 years (fiscal years 1984 and 1985), the PPS payment rates were required to be adjusted so that aggregate payments to hospitals included in PPS would be equal to the aggregate payments they would have received if they had been paid under the provisions of prior law (the target rate of increase limits established in TEFRA, Public Law 97-248). As a result of the budget neutrality adjustment, the actual increases in the DRG prices were lower than the increases provided by the PPS update factors for those years, which were set at the market basket increase plus 1 percentage point (5.9 percent) in fiscal year 1984, and the market basket increase plus one-quarter of 1 percentage point (4.4 percent) in fiscal year 1985. In fiscal year 1986, the PPS rates were frozen by the Congress and the update factor of 0.5 percent established in COBRA (Public Law 99-272) applied for only the last 5 months of the fiscal year. Actual increases in the DRG rates in each year also have been affected by changes in policy that required recalculation or adjustment of the Federal base payment amounts or the DRG relative weights.

Actual annual increases in average payments per case depend on a variety of factors in addition to the increase in the PPS rates. Average payments per case include PPS operating payments (DRG payments), payments for the indirect costs of medical education programs, payments for direct medical education costs, payments for capital-related costs and other passthrough payments (kidney acquisition costs, etc.) and payments to hospitals and units excluded from PPS. Therefore, annual increases in average payments per case depend on the increase in the PPS payment rates (which may be larger or smaller than the update factor), the increase in reported case mix and the increases in payments for medical education, capital costs, and payments to excluded hospitals and units. In addition, the increase in actual average payments per case is influenced by changes in other policies. For example, the phaseout of payments for a return on equity capital for proprietary providers will reduce the increase in average payment per case. Similarly, policy changes that increase the number of cases in which the Medicare program is the secondary payer also reduce the increase in the average payment per case. Thus, average payments per discharge may be influenced by factors unrelated to PPS payment policy.

TABLE 17.—HISTORICAL TRENDS IN FACTORS AFFECTING PPS RATES AND AVERAGE PAYMENTS PER CASE

[Percentage change from previous year]

Fiscal year	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
Market basket index [1]	8.1	5.5	4.9	4.1	2.9	3.2	4.7	5.6	4.8	5.2	5.5
Annual update factor [2]						1.15	1.76	3.33	5.71	2.83	(3)
Case mix index			8.4	2.5	2.7	2.4	2.0	1.0	.78	2.0	2.0
Average payments per discharge [4]	14.0	10.4	10.4	14.9	7.1	4.1	3.4	10.5	7.5	5.2	7.3
Average payment per beneficiary [4]	15.4	11.7	7.2	6.0	2.9	.1	2.1	8.2	13.0	2.9	8.6
GNP deflator	6.4	3.8	3.9	3.4	2.9	3.2	4.2	4.4	4.4	4.7	4.0

[1] Historical data through fiscal year 1990, fiscal year 1992 President's Budget estimates in fiscal years 1991 and 1992.

[2] Figures represent average update factors for the year.

[3] Average update estimated at market basket minus 1.43 percent.

[4] Estimates for fiscal years 1989 and 1990 include the effect of provisions of the Medicare Catastrophic Coverage Act of 1988. Estimates for fiscal years 1989 and 1990 include the effect of provisions of the Medicare Catastrophic Coverage Act of 1988.

Source: HCFA Division of Budget and Office of the Actuary. Fixed weight GNP price index estimates for 1991–92 from Congressional Budget Office.

TABLE 18.—SUMMARY CHARACTERISTICS OF PPS HOSPITALS

	Number of hospitals [1]	Estimated medicare discharges (thousands, 1992)	Average number of beds (1988)	Estimated average case mix (1992) [2]	Average wage index (1991) [3]	Estimated PPS payment (dollars per case, 1992) [4]
All	5,633	10,379	152	1.425	0.982	5,522
Urban	3,064	8,178	221	1.464	1.020	6,028
Rural	2,569	2,201	69	1.225	0.797	3,641
MSA >1 million [5]	1,519	4,151	238	1.469	1.099	6,592
Other urban	1,545	4,027	203	1.456	0.937	5,447
Rural referral	254	713	197	1.349	0.804	4,268
Rural sole community [6]	449	272	52	1.170	0.821	3,760
Other rural	1,866	1,215	56	1.157	0.786	3,245
Major teaching [7]	227	942	447	1.616	1.105	9,383
Other teaching	965	3,559	286	1.491	0.997	6,036
Nonteaching	4,441	5,879	107	1.327	0.936	4,592
Disproportionate share:						
MSA > 1 million	589	1,608	282	1.494	1.138	7,776
Other urban	638	1,928	252	1.479	0.922	5,835
Rural	328	342	86	1.226	0.755	3,662
Nondisproportionate share	4,078	6,501	122	1.391	0.963	4,969
New England	240	562	179	1.412	1.106	6,285
Middle Atlantic	636	1,813	237	1.412	1.065	6,184
South Atlantic	767	1,708	175	1.441	0.908	5,194
East North Central	841	1,806	179	1.412	0.971	5,404
East South Central	480	863	137	1.357	0.821	4,400
West North Central	792	849	94	1.426	0.891	4,872
West South Central	797	1,105	126	1.418	0.862	4,891
Mountain	394	454	94	1.432	0.977	5,320
Pacific	686	1,219	143	1.483	1.197	6,713
Urban less than 100 beds	749	466	58	1.224	0.999	4,407
Urban 100 to 249 beds	1,273	2,595	165	1.363	1.016	5,339
Urban 250 to 499 beds	846	3,712	343	1.488	1.014	6,110
Urban 500 or more beds	196	1,405	673	1.622	1.043	7,623
Rural less than 51 beds	1,356	444	32	1.092	0.796	3,153
Rural 51 to 100 beds	732	663	73	1.180	0.797	3,428
Rural 101 to 200 beds	364	679	137	1.255	0.801	3,732
Rural 201 or more beds	117	416	267	1.372	0.793	4,350
Voluntary [8]	3,187	7,427	180	1.439	1.000	5,669
Proprietary	1,109	1,478	119	1.384	0.942	4,931
Urban government	437	871	217	1.479	0.991	6,660
Rural government	900	602	58	1.193	0.786	3,510

---

[1] Number of hospitals for which data were available for PPS payment simulations.

[2] Weighted by case-mix-adjusted PPS payments. The unweighted average across all hospitals is 1.250.

[3] Wage index (effective January 1, 1991), weighted by wage-index-adjusted PPS payments. The unweighted average across all hospitals is 0.915.

[4] Incurred payments (including copayments) divided by the number of Medicare discharges.

[5] MSA > 1 million indicates hospitals located in Metropolitan Statistical Areas with populations of more than 1 million.

[6] Sole community hospitals that are also rural referral hospitals are included in the rural referral category.

[7] Major teaching hospitals are those hospitals for which the ratio of the number of full-time equivalent interns and residents to the number of beds is .25 or larger.

[8] This category includes 90 hospitals of unknown ownership type.

Note: Years refer to federal fiscal years.

Source: Congressional Budget Office estimates based on data from the Health Care Financing Administration and the Prospective Payment Assessment Commission.

Additional hospital data

Table 18 displays summary characteristics of hospitals participating in the Medicare program. These data are derived from CBO PPS payment simulations.

TABLE 19.—THE CHANGE IN PPS PAYMENTS UNDER OBRA 1990 RELATIVE TO PREVIOUS LAW (FISCAL YEARS 1991, 1995, AND THE 1991–95 PERIOD)

Category	Number of hospitals	PPS payments under previous law (1991, in millions of dollars) [1]	Change in PPS Payments Under OBRA 1990 (In percent)		
			1991	1995	1991–95
Total	5,737	52,820	−2.0	−3.7	−3.4
Urban	3,109	45,290	−2.1	−4.0	−3.7
Rural	2,628	7,540	−1.5	−2.1	−2.0
Urban:					
MSA > 1 million [2]	1,548	25,300	−2.1	−3.8	−3.6
Other urban	1,561	19,990	−2.1	−4.1	−3.7
Rural:					
Rural referral	218	2,530	−2.1	−4.4	−3.9
Not rural referral	2,410	5,010	−1.2	−0.9	−1.0
Sole community [3]	439	920	−1.4	−0.9	−1.0
Medicare dependent [4]	485	720	−1.3	−0.9	−1.0
Other rural	1,486	3,360	−1.1	−0.9	−0.9
Disproportionate share—total	1,577	21,830	−2.0	−3.3	−3.3
MSA > 1 million	574	11,000	−2.1	−3.0	−3.2
Other urban	620	9,660	−2.0	−3.7	−3.5
Rural	383	1,170	−1.8	−2.1	−2.1
Nondisproportionate share total	4,160	30,990	−2.0	−4.0	−3.5
MSA > 1 million	974	14,310	−2.2	−4.5	−3.9
Other urban	941	10,320	−2.1	−4.5	−3.9
Rural	2,245	6,360	−1.5	−2.1	−2.0
Teaching	1,191	27,540	−2.0	−3.8	−3.6
Nonteaching	4,546	25,280	−2.0	−3.5	−3.3
Major teaching [5]	228	8,000	−2.1	−3.3	−3.3
Disproportionate share	176	5,930	−2.0	−2.9	−3.1
Nondisproportionate share	52	2,070	−2.4	−4.5	−3.9
Other teaching	963	19,540	−2.0	−4.0	−3.7
Disproportionate share	421	8,650	−2.0	−3.6	−3.5
Nondisproportionate share	542	10,900	−2.0	−4.4	−3.9

TABLE 19.—THE CHANGE IN PPS PAYMENTS UNDER OBRA 1990 RELATIVE TO PREVIOUS LAW (FISCAL YEARS 1991, 1995, AND THE 1991–95 PERIOD)—Continued

Category	Number of hospitals	PPS payments under previous law (1991, in millions of dollars) [1]	Change in PPS Payments Under OBRA 1990 (In percent)		
			1991	1995	1991–95
Urban:					
≤ 100 beds	846	2,330	−2.2	−4.4	−4.0
101–200 beds	870	7,230	−2.2	−3.9	−3.7
201–400 beds	1,002	19,660	−2.1	−4.0	−3.7
401+ beds	391	16,070	−2.1	−3.9	−3.6
Rural:					
≤ 50 beds	1,390	1,370	−1.2	−0.9	−1.0
51–100 beds	744	2,100	−1.2	−1.0	−1.0
101–200 beds	379	2,450	−1.6	−2.5	−2.3
201+ beds	115	1,620	−2.0	−3.8	−3.5
New England	244	3,280	−2.5	−4.5	−3.6
Middle Atlantic	637	10,510	−2.5	−4.1	−3.7
South Atlantic	781	8,030	−2.6	−3.9	−3.6
East North Central	868	9,150	−1.0	−4.2	−3.1
East South Central	493	3,420	−2.0	−3.5	−3.2
West North Central	799	3,770	−1.4	−3.8	−3.3
West South Central	824	4,930	−1.7	−3.7	−3.3
Mountain	398	2,200	−2.1	−3.9	−3.5
Pacific	693	7,530	−2.2	−4.0	−3.6
Voluntary	3,235	39,160	−2.0	−4.2	−3.5
Proprietary	1,161	6,370	−2.2	−3.8	−3.4
Urban government	447	5,330	−2.0	−3.6	−3.2
Rural government	894	1,960	−1.5	−1.5	−1.8

[1] Prospective payment system [PPS] payments are the payments received by hospitals covered by the PPS for the operating costs associated with providing inpatient services to Medicare beneficiaries, which include enrollees' copayments. They are based on prospectively set rates for each diagnosis-related group and include adjustments such as those for "disproportionate share" and indirect teaching costs. They do not include payments for capital-related expenses, the direct costs of graduate medical education, or other "pass-throughs."

[2] MSA > 1 million indicates hospitals located in Metropolitan Statistical Areas with populations of more than 1 million.

[3] Sole community hospitals that are also rural referral hospitals are included in the rural referral category.

[4] A Medicare dependent hospital is a rural hospital with 100 or fewer beds that is not a sole community hospital, and in which at least 60 percent of inpatient discharges or days during the hospital's 1987 fiscal year were attributable to Medicare beneficiaries. Medicare dependent hospitals qualify for payments similar to those for sole community hospitals (through March 1993).

[5] Major teaching hospitals are those hospitals for which the ratio of the number of full-time equivalent interns and residents to the number of beds is .25 or larger.

Notes: The estimates in the table are incurred amounts for fiscal years under CBO's summer 1990 baseline. OBRA 1990 refers to the Omnibus Budget Reconciliation Act of 1990. Previous law means the law in effect on September 30, 1990. Details may not sum to totals because of rounding.

Source: Congressional Budget Office estimates based on data provided by the Health Care Financing Administration and other sources.

Estimated effects on PPS hospitals

Table 19 shows the effects of OBRA 1990 on PPS payments. In fiscal year 1991, PPS payments will be approximately 2.0 percent less than they would have been under previous law. Although payments will be reduced in all hospitals, the size of the reductions will vary among hospitals according to urban-rural status, region of the country, and certain hospital characteristics. The average reduction in payments to urban hospitals will be larger than for rural hospitals, 2.1 percent for urban hospitals compared with 1.5 percent for rural hospitals. In fiscal year 1995, when the provisions of OBRA 1990 will be fully in place, total PPS payments will be 3.7 percent less than they would have been under previous law.

HIGHLIGHTS OF LEGISLATION AND REGULATIONS AFFECTING THE PROSPECTIVE PAYMENT SYSTEM

Medicare's Prospective Payment System (PPS) for hospitals has evolved through legislation and regulation. The original authorizing legislation, the Social Security Amendments of 1983 (P.L. 98-21), was first implemented by interim final rules issued by the Department of Health and Human Services on September 1, 1983 (48 FR 39752), and final rules issued on January 3, 1984 (49 F.R. 234).

The Deficit Reduction Act of 1984 (P.L. 98-369) made certain changes to PPS. These changes were incorporated into final rules issued by the Department on August 31, 1984 (49 F.R. 34728).

The Department issued final rules on September 3, 1985 (50 F.R. 35645) making certain changes to PPS and freezing the PPS payment rates for fiscal year 1986. However, none of the payment features of these final rules became effective.

The payment features the Department would have applied to fiscal year 1986 could not be implemented because the Emergency Extension Act of 1985 (P.L. 99-107, as amended by P.L. 99-201) extended the payment provisions that were in effect on September 30, 1985 (the final day of fiscal year 1985), through March 14, 1986. The fiscal year 1985 payment provisions were extended again, through April 30, 1986, by Public Law 99-272. The extension of the fiscal year 1985 payment provisions into fiscal year 1986 had many effects, including a delay in the PPS transition schedule.

The Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177, known as the Gramm-Rudman-Hollings Act) reduced Medicare payments to hospitals in fiscal year 1986.

Two reconciliation bills in the 99th Congress changed a number of PPS provisions. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272, known as COBRA) was implemented by an interim final rule on May 6, 1986 (51 F.R. 16771), and a final rule on September 3, 1986 (51 F.R. 31453). The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) was accompanied by a final rule on November 24, 1986 (51 F.R. 42229).

Several features of the PPS, including the calculation of the wage index, the inclusion of hospitals in Puerto Rico and alcohol and drug abuse hospitals and distinct part units in the PPS, were altered by a final regulation published on September 1, 1987 (52 FR 33034). Changes in hospital payments required by Public Law 100-119 were implemented by a final regulation published on October

23, 1987 (52 FR 39637). A notice implementing the provisions of Public Law 100-203 (OBRA 1987) was issued April 5, 1988 (53 FR 11134). Regulations issued September 30, 1988 (53 FR 38476), established payment rates for fiscal year 1989 and made various changes in PPS rules, especially the treatment of outlier cases.

Public laws 100-360, 100-485, and 100-647 made minor and technical changes to PPS provisions, especially those contained in OBRA 1987. Public Law 101-239, along with regulations issued September 1, 1989 (54 FR 36452) and December 29, 1989 (54 FR 53753), made additional changes to PPS rules. The Continuing Resolution of October 1, 1990, Public Law 101-403, extended the regional floor and provided for PPS payments through October 20, 1990. Public Law 101-508, OBRA 1990, provides a 5-year deficit reduction plan which would reduce total Medicare outlays by $43.1 billion between fiscal year 1991 and 1995. These provisions, along with regulations issued September 4, 1990 (55 FR 35990), and January 7, 1991 (56 FR 562), made further changes in PPS rules.

Legislation and regulations which changed selected features of the prospective payment system are highlighted as follows:

Increases in Medicare payments to hospitals

Public Law 98-21 and 49 F.R. 234: Provides that the Medicare DRG payment rates for fiscal years 1984 and 1985 would be increased annually by the increase in the hospital market basket plus 1 percentage point, subject to a budget neutrality requirement which provides that Medicare payments in those 2 years must equal what would have been spent if PPS had not been put in place. Provides that the Secretary would determine the rate of increase for fiscal year 1986 and thereafter, taking into account the recommendations of the Prospective Payment Assessment Commission.

Public Law 98-369 and 49 F.R. 34728: Changes the annual increase in the DRG payment rates for fiscal year 1985 to the increase in the market basket plus 0.25 percentage point, subject to budget neutrality. Limited the rate of increase to be determined by the Secretary for fiscal year 1986 to the rate of increase in the market basket plus 0.25 percentage point.

50 F.R. 35645: The Secretary promulgated a zero rate of increase in the DRG payment rates for fiscal year 1986.

Public Law 99-107: Provided that the payment rates in effect on September 30, 1985, would remain in effect until November 14, 1985. Public Laws 99-155, 99-181, 99-189 and 99-201 extended this requirement through March 14, 1986. (The freeze was extended through April 30, 1986, by P.L. 99-272.)

Public Law 99-177: Reduced fiscal year 1986 Medicare payments to hospitals by 1 percent beginning March 1, 1986.

Public Law 99-272, 51 FR 16771, and 51 FR 31453: Provided that the fiscal year 1986 PPS payment rates would be frozen at fiscal year 1985 levels until May 1, 1986, and would be increased ½ percent for the remainder of the year.

Public Law 99-509 and 51 FR 42229: Increased the payment rates for PPS hospitals by 1.15 percent in fiscal year 1987 and by the hospital market basket minus 2 percentage points in fiscal year 1988.

Public Law 100–119, 52 FR 39637: Provided an update of zero percent for the period from October 1, 1987, to November 20, 1987. The final sequester order pursuant to this legislation reduced all Medicare payments to hospitals by 2.324 percent beginning on November 21, 1987. The update of 2.7 percent mandated by Public Law 99–509 (52 FR 33034) also went into effect on November 21, 1987.

Public Law 100-203, 53 FR 11134, 53 FR 38476: required that the sequestration reduction mandated by Public Law 100–119 continue through March 31, 1988. Beginning on April 1, 1988, instead of the 2.7 percent update provided by Public Law 99–509, the PPS payment rates are increased by 3 percent for hospitals located in a rural area, by 1.5 percent for hospitals located in an urban area with a total population of more than 1 million persons (large urban areas), and by 1 percent for hospitals located in other urban areas. For fiscal year 1989, the update is equal to the increase in the market basket index minus 1.5 percentage points for hospitals located in a rural area, minus 2 percentage points for hospitals located in a large urban area, and minus 2.5 percentage points for hospitals located in other urban areas. The market basket increase for 1989 was forecast at 5.4 percent, resulting in the following rate increases: rural, 3.9 percent; large urban, 3.4 percent; other urban 2.9 percent.

Public Law 101–239 and 54 FR 53753: Sets the following update factors for fiscal year 1990 for discharges occurring on or after January 1, 1990: for hospitals located in large urban areas, the market basket minus 0.12 percentage points; for hospitals in other urban areas, the market basket minus 0.53 percentage points; and for hospitals in rural areas, the market basket plus 4.22 percentage points. In addition, OBRA 1989 included a DRG weighting factor reduction of 1.22 percent for discharges in fiscal year 1990, that effectively reduces PPS payments by 1.22 percent. The net effect of this reduction produces the following actual fiscal year 1990 update factors for hospitals in large urban, other urban, and rural areas: market basket minus 1.1 percentage points; market basket minus 1.75 percentage points; and the market basket plus 3.0 percentage points, respectively. For fiscal year 1990, the market basket increase is estimated to be 5.5 percent, providing the following final update factors for fiscal year 1990: 4.4 percent for large urban hospitals, 3.75 percent for other urban hospitals, and 8.5 percent for rural hospitals.

Public Law 101–403: Extended the regional floor through October 20, 1990, on a budget neutral basis.

Public Law 101–508 and 56 FR 562: Provides for a freeze in hospital payments at fiscal year 1990 levels for the period from October 21, 1990 through December 31, 1990, deeming the market basket increase applicable to PPS payments to be equal to zero for this period. Includes a phase-out of the payment differential between other urban and rural hospitals, through the use of separate update factors for other urban and rural hospitals designed to eliminate the differences between other urban and rural standardized amounts by fiscal year 1995. Set separate update factors for hospitals located in large and other urban areas, and for hospitals located in rural areas. For large and other urban hospitals, the following update factors are: for fiscal year 1991, for discharges occurring on or after January 1, 1991, the market basket increase (MBI) minus 2.0 percentage points; for fiscal year 1992, the MBI minus 1.6 percentage points; for fiscal year 1993, the MBI minus 1.55 percentage points; and for fiscal years 1994–95, the full MBI. The update factors for rural hospitals are: for fiscal year 1991, for discharges occurring on or after January 1, 1991, the MBI minus 0.7 percentage points; for fiscal year 1992, the MBI minus 0.6 percentage points; for fiscal year 1993, the MBI minus 0.55 percentage points; for fiscal year 1994, the MBI plus 1.5 percentage points; and, for fiscal year 1995, the amount necessary to provide rural hospitals with an average standardized amount equal to that of other urban hospitals.

Wage index

Public Law 98–21: Provided that the Federal portion of the DRG rates be adjusted by a wage index to reflect the hospital wage level in an individual hospital's geographic area relative to the national average hospital wage level.

49 FR 234: The Department indicated it would use employment data from the Bureau of Labor Statistics (BLS) to develop the wage index. While acknowledging the limitations of the BLS data (including lack of information about part time employment), the Department stated that BLS data are the best presently available for the development of the wage index.

Public Law 98–369: Required the Secretary, in consultation with the Secretary of Labor, to conduct a study to develop an appropriate wage index, taking into account wage differences of full-time and part-time employees. The results of the study were to be reported to Congress by August 18, 1984. If any changes are made to the wage index as a result of this study, the Secretary is required to make retroactive adjustments to the payment amounts for hospital cost reporting periods beginning on or after October 1, 1983. Required the Secretary to study and report to Congress proposed criteria to be used to modify a hospital's wage adjustment if the hospital can demonstrate that the wage index does not accurately reflect wage levels in the labor market serving the hospital.

49 FR 34728: The Department indicated that it surveyed the hospitals subject to PPS to obtain wage and employment data which could be used to develop an improved wage index. However, the data obtained had too many errors to develop a reliable wage index in time for the publication of the August 1984 rules. The Department is planning to use these data, once they are determined to be accurate and reasonably complete, to conduct the mandated study and to construct a revised wage index. The Department indicated that any revised wage index will be retroactive to October 1, 1983, as mandated by law. The Department indicated that it does not intend to address the development of adjustment criteria in the near future.

50 F.R. 35645: The Department promulgated final regulations to implement the survey-based gross wage index retroactive to October 1, 1983. The survey-based wage index used to determine the amount of a hospital's underpayment or overpayment would be based on the recognized urban/rural definition in effect for the entire Federal fiscal year for which the payment adjustment determination is being made. The payment adjustments will be spread out over the course of one year, rather than requiring lump-sum payments to minimize the negative impact on overpaid hospitals.

Public Law 99-107: Provided that Medicare hospital payment amounts would be determined on the same basis as they were on September 30, 1985. Public Laws 99-155, 99-181, 99-189 and 99-201 extended this requirement through March 14, 1986. This means that there can be no change in the wage index until after this date. (This was extended through April 30, 1986, by P.L. 99-272.)

Public Law 99-272: Mandated that the gross wage index be used beginning on May 1, 1986. Also eliminated the requirement for retroactive adjustment of hospital payments.

52 F.R. 33039: Changed the method of calculating the national average wage level, and updated the wage index data. The national average wage level is now calculated by dividing national aggregate wages and salaries by the national aggregate number of paid hours of hospital employment. The Secretary also used new data; wages and salaries and paid hours of employment for hospital cost reporting periods beginning during fiscal year 1984 (the first year of the PPS). However, in order to avoid large changes in index values for individual areas, the Secretary adopted a blended wage index, which is calculated by adding together the 1982 and the 1984 index values for each area and dividing the resulting sum by 2. Wage index values for urban and rural labor market areas located in Puerto Rico are based solely on 1984 data. The new index took effect for discharges occurring on or after October 1, 1987.

Public Law 100-203: Requires the Secretary to update the wage index by October 1, 1990, and at least every 3 years thereafter. Updates are to be based on a periodic survey of the wages and wage related costs of PPS hospitals. To the extent feasible, the survey must be designed to measure earnings and hours of paid employment by occupational category, and to permit exclusion of the wages and wage related costs hospitals incur in providing skilled nursing facility services.

53 F.R. 38476: Continued use of the wage index based on a blend of 1982 and 1984 data. The new index also took account of certain legislative changes, such as the redesignation of certain rural counties as urban.

Public Law 100-647: Required adjustments in the wage index to ensure that, for discharges during fiscal years 1990 and 1991, no other area suffers a reduced wage index because of the shifting of one of these counties. The Secretary is required to report to Congress by January 1989 on possible ways of reducing the adverse impact on wage index values during fiscal year 1989.

54 FR 36452: Changed the method of calculating the wage index from the blended wage index based on 1982 and 1984 wage data to an index based solely on 1984 wage data for discharges occurring in fiscal year 1990.

Public Law 101-239: Requires the Secretary to update the area wage index annually in a budget neutral manner, beginning in fiscal year 1993.

55 FR 35990: Changed the method of calculating the wage index to one basing the index on 1988 wage survey data, but included temporary protections for hospitals most severely affected by a shift from the 1984 to the 1988 survey data.

Public Law 101-403: Extended the use of the wage index in effect on September 30, 1990 for discharges occurring on or after October 1, 1990 through October 20, 1990.

Public Law 101-508 and 56 FR 562: Extends the use of the wage index in effect on September 30, 1990 for discharges occurring on or after October 21, 1990 through December 31, 1990. Requires the use of a wage index based solely on the 1988 wage survey, for discharges occurring on or after January 1, 1991 and before October 1, 1993. Requires ProPAC to study the available data on wages by occupational category and include its recommendations on modifying the wage index to account for occupational mix in the March 1991 report to Congress.

Referral centers

Public Law 98-21: Required the Secretary to provide for such exceptions and adjustments to the DRG payment amounts as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including hospitals of 500 or more beds located in rural areas).

49 F.R. 234: The Department's criteria for a referral center were that the hospital must be located in a rural area and have at least 500 beds; or the hospital must have an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital, at least 60 percent of the hospital's Medicare patients reside more than 25 miles from the hospital, and at least 60 percent of all services received by Medicare beneficiaries are provided to beneficiaries residing more than 25 miles from the hospital. Such hospitals would be paid on the basis of the higher urban rates, rather than the rural rates. No adjustment was provided for rural referral centers with fewer than 500 beds or for referral centers located in urban areas.

Public Law 98-369: Provided that a rural hospital may appeal to the Secretary to be classified as a rural referral center on the basis of criteria established by the Secretary which would allow the hospital to demonstrate that it should be so classified because it has characteristics (such as wages, scope of services, service area, and mix of medical specialties) similar to those of a typical urban hospital located in the same census region.

49 F.R. 34728: The Department broadened the definition of a rural referral center to include rural hospitals that meet a case mix index threshold, a minimum number of discharges, and one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are inpatients residing more than 25 miles from the hospital, or at least 40 percent of inpatients have been referred either from other hospitals or from physicians not on the hospital's staff.

50 F.R. 35645: The Department changed the qualifying criteria for referral centers by (1) specifying the methodology for and updating the case mix index thresholds (i.e., either the national case mix index value of 1.1294 or the median urban case mix index value for the hospital's region), and (2) specifying the threshold for the required number of discharges (i.e., either the national discharge criterion of 6,000 or the median number of urban discharges for the hospital's region).

Public Law 99-272: Reduced the requirement that a hospital have at least 6,000 or more discharges a year to 3,000, but only for osteopathic hospitals.

51 F.R. 31453: Reduced the requirement for all other hospitals to 5,369 (or a number at least equal to a specific number of discharges calculated for each census region).

Public Law 99-509: Reduced that requirement further to 5,000. Public Law 99-509 also specified that teaching hospitals should not be considered when calculating the median case mix for urban hospitals located in the same region.

52 F.R. 33034: Updated the national and regional case mix and discharge standards.

Public Law 100-203 and 53 F.R. 11134: Reduced the minimum number of beds criterion for hospitals located in a rural area, from 500 to 275, effective for discharges occurring on or after April 1, 1988. The legislation also requires the Secretary to study and report to Congress, by May 1, 1989, on (1) the referral center criteria, including, for hospitals currently designated as referral centers, the relationship of their PPS payments to their costs of inpatient care, and the appropriateness of payment on the basis of some rate other than the "other urban area" rate, and; (2) recommendations regarding criteria to be used in designating referral centers for cost reporting periods beginning on or after October 1, 1989.

Public Law 101-239 and 54 FR 53753: Extends the classification of hospitals as rural referral centers for cost reporting periods beginning on or after October 1, 1989 and before October 1, 1992. The extension applies to hospitals classified as rural referral centers on or before September 30, 1989.

Outliers

Public Law 98-21: Required the Secretary to provide for additional payments to hospitals for atypical cases, "outliers" whose length of stay exceeds the mean by a fixed number of days or a fixed number of standard deviations, whichever is fewer; or cases which do not meet the length of stay criteria but have charges adjusted to cost that exceed a fixed multiple of the DRG rate, or some other fixed dollar amount, whichever is greater. Provides that total outlier payments in a fiscal year must be between 5 and 6 percent of total projected DRG payments for that year.

49 F.R. 234: For fiscal year 1984, the Department defined a "day" outlier case as one for which the length of stay exceeds the average length of stay for that DRG by the lesser of 20 days or 1.94 standard deviations. The additional payment for each outlier day beyond the threshold would be 60 percent of the hospital's Federal payment amount for the DRG divided by the average length of stay for the DRG. A "cost" outlier case was defined as one for which covered charges, adjusted to operating costs, exceed the greater of 1.5 times the hospital's Federal payment amount for the DRG or $12,000. For cost outliers, the additional payment is 60 percent of the difference between the hospital's adjusted charges for the discharge and the threshold. The Department expected that under these criteria, outlier payments would approximate 6 percent of total payments to hospitals. No provision was made for outlier payments to transferring hospitals.

49 F.R. 3472: Updated the outlier thresholds and permitted a hospital that transfers a high cost patient on or after October 1, 1984, to receive cost outlier payment.

50 F.R. 35645. Updated the outlier thresholds.

Public Law 99-509 and 51 F.R. 42229: Established a separate urban and a separate rural set-aside factor for outliers. As a result, instead of the uniform 5 percent reduction factor applied to all of the standardized amounts, there are now two factors, one for urban standardized amounts and one for rural standardized amounts. Overall, outlier payments are required to be made at the same level as they were before this provision was enacted.

Public Law 100-203: Increased payments for outlier cases classified in DRGs relating to patients with burns from April 1, 1988, through September 30, 1989. This legislation also prohibited the Secretary from issuing any final regulations before September 1, 1988, which change the method of payment for outlier cases (other than burn cases).

53 F.R. 38476: Modified the thresholds used in determining whether a case is an outlier and increased the allowable payment amounts for cost outliers, effective November 1, 1988 (transitional rules were established for discharges during October 1988). The new threshold for length of stay outliers was the lesser of 24 days or 3 standard deviations; for cost outliers it was the greater of $28,000 or 2 times the DRG rate. The marginal cost factor for cost outliers (other than burn cases) was raised to 75 percent.

54 FR 36452: Modified the thresholds for determining whether a case is an outlier and increased the allowable payment amounts for cost outliers for fiscal year 1990. The new threshold for length of stay outliers is the lesser of 28 days or 3 standard deviations; for cost outliers it is the greater of $34,000 or two times the PPS payment.

55 FR 35990: Modified the thresholds for determining whether a case is an outlier and increased the allowable payment amounts for cost outliers for fiscal year 1991. The new threshold for length of stay outliers is the lesser of 29 days or three standard deviations; for cost outliers, the greater of $35,000 or 2 times the PPS payment.

Payment for indirect medical education

Public Law 98-21: Provided for additional payments to hospitals for the indirect costs of medical education, computed at twice the level of the educational adjustment factor provided under regulations in effect as of January 1, 1983—under the former "section 223" cost limits. The Federal portion of a hospital's DRG payments is then increased by this doubled factor.

49 F.R. 234: The educational adjustment factor in effect as of January 1, 1983 was 6.06 percent for each 0.1 increase, (above zero), in the ratio of a hospital's full-time equivalent interns and residents to its number of beds. Full-time equivalent interns and residents were defined as the sum of those employed for 35 hours or more per week, plus one-half of the total number of interns and residents working less than 35 hours per week. A hospital was allowed to count only interns and residents who were employed by and furnishing services at that hospital (excluding those employed by the hospital but furnishing services at another site).

Under PPS, the Department provided for an education adjustment factor of 11.59 percent (rather than twice the 6.06 percent factor provided in the earlier regulations). The regulations indicated that 11.59 percent was the appropriate increase after recomputing the factor using the data base on which the DRG payments were based, instead of the data base used to calculate the earlier factor. Criteria for determining which interns and residents could be counted were kept the same as in earlier regulations, except interns and residents furnishing services in the hospital but employed by an organization with a long-standing historical medical relationship with the hospital could be included.

Public Law 98-369: Provided that, effective October 1, 1984, all interns and residents who furnish services to a hospital are to be counted for purposes of determining that hospital's indirect medical education adjustment, regardless of whether or not the interns and residents are employees of that hospital.

49 F.R. 34728: To conform with the change in law, the Department indicated that it would now count full-time interns and residents on the basis of where their services were provided. When working at more than one hospital, each intern's or resident's time would be apportioned to each facility. To avoid the potential for counting interns and residents more than once, the Department is requiring hospitals to submit quarterly reports documenting the time worked by interns and residents. The final lump-sum payment for indirect medical education costs will not be made until the audit of a hospital's cost report is completed.

50 F.R. 35645: The Department changed the method used to determine the number of beds in a hospital for purposes of counting interns and residents for cost reporting periods beginning on or after October 1, 1984. In addition, the requirement that a hospital provide a quarterly report on the number of interns and residents was replaced with an annual report that counts the number of interns and residents on September 1 (with an additional count on April 15, 1985 for hospitals with cost reporting periods beginning on or after October 1, 1984 and before July 1, 1985). The requirement of counting hours of interns and residents to determine full-time equivalents was deleted. Instead, all interns and residents assigned to the hospital on September 1 (or April 15, 1985 if applicable) will be counted as full-time except for those individuals splitting their time between prospective payment areas and one or more areas excluded from PPS, or spending all their time in excluded areas. The intermediary will be required to review the hospital's documentation to verify the hospital's intern- and resident-to-bed ratio.

Public 99-272, 51 F.R. 16771, and 51 F.R. 31453: Based the additional payment to a hospital on a formula that provides an increase of approximately 8.1 percent in the Federal portion of the DRG payment, from May 1, 1986, to October 1, 1988 (when the disproportionate share adjustment was scheduled to expire). The payment increases with the ratio of a hospital's interns and residents to its bed size on a curvilinear or variable basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size). The payment adjustment after October 1, 1989, would be an increase of approximately 8.7 percent.

Public Law 99-509: Extended the disproportionate share adjustment, and the reduction in the teaching adjustment to 8.1 percent, until October 1, 1989.

Public Law 100-203 and 53 F.R. 38476: Extended the disproportionate share adjustment to October 1, 1990, and reduced the teaching adjustment factor from approximately 8.1 percent to approximately 7.7 percent, effective for discharges occurring on or after October 1, 1988, but before October 1, 1990. The adjustment for discharges occurring on or after October 1, 1990 (when the disproportionate share adjustment was originally scheduled to expire), is also reduced from 8.7 percent to 8.3 percent.

Public Law 100-647: Extended the teaching adjustment of 7.7 percent through September 30, 1995.

Public Law 101-508: Makes the indirect medical education adjustment of 7.7 percent permanent.

Disproportionate share hospitals

Public Law 98-21: Required the Secretary to make adjustments to PPS rates, as deemed appropriate, to account for hospitals that serve a disproportionate share of low-income patients.

Public Law 99-272: Specified the amount of additional payments to hospitals serving a disproportionate share of low-income patients, and the criteria to qualify for the payments, varying with the location and size of the hospital, and percentage of low-income patients seen at the hospital (the disproportionate patient percentage). Defined the disproportionate patient percentage as the hospital's total number of days attributable to Medicare beneficiaries who also receive Federal Supplemental Security Income payments divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days. Also established payments to urban hospitals with 100 or more beds and 30 percent of their net revenues derived from State and local government payments for indigent care. The new disproportionate share rules applied only for discharges between May 1, 1986, and September 30, 1989.

Public Law 100-203: Extended the additional payment for disproportionate share hospitals until September 30, 1990. Increased the adjustment for urban hospitals with 100 or more beds receiving more than 30 percent of their net inpatient revenues from State and local government funds for indigent care.

Public Law 100-647: Extended the authority for the disproportionate share adjustment until September 30, 1995.

Public Law 101-239 and 54 FR 53753: Increased the disproportionate share adjustment for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, for rural referral centers, and for sole community hospitals. Reduced the disproportionate patient percentage required for a sole community hospital or rural hospital with 100 or more beds to qualify for the adjustment. (See table 4 for details of criteria and adjustment formulas.)

Public Law 101-508: Increased the disproportionate share adjustment for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, and for hospitals qualifying for the adjustment based on revenue for indigent care received from State and local governments. Also made the DSH adjustment permanent.

Urban/rural boundaries

Public Law 98-21 and 49 F.R. 234: Provided that hospitals in urban areas are paid different Federal DRG rates than hospitals located in rural areas. Urban areas are defined as those located within a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA). Rural areas are those not classified as urban areas. Provided that during a 3-year transition period, hospitals are paid on the basis of Federal DRG payment amounts calculated separately for each of the nine census regions of the country.

Public Law 98-369: Provided that hospitals located in an MSA that crosses census region boundaries be deemed to be in the region in which a majority of the hospitals in that MSA are located or, at the option of the Secretary, the region from which the majority of the Medicare inpatient discharges within that MSA are made. In addition, provided that hospitals located in counties redesignated from urban to rural because of a change in the MSA or NECMA classification system since April 20, 1983, are allowed a 2-year transition to the lower rural payment rates. In the first hospital cost reporting period, the hospital would be paid the rural rate plus two-thirds of the difference between its rural and urban rates. In the second year, it would be paid the rural rate plus one-third of the difference between its rural and urban rates.

Public Law 100-203: Changed the standards for including a rural county adjacent to an urban area in the definition of the urban area. If (1) at least 15 percent of employed residents of the rural county commute to one or more adjacent urban areas for employment, or (2) the sum of the number of county residents commuting to all adjacent urban areas plus the number of residents of all adjacent urban areas commuting to the rural county for employment, is at least equal to 20 percent of the employed population of the county, then the rural county would be included in the definition of the urban area to which the greatest number of its residents commute.

Public Law 100-647: Requires adjustments to ensure that, for discharges during fiscal years 1990 and 1991, no other area suffers a reduced wage index because of the shifting of one of these counties.

Public Law 101-239: Requires the Secretary to establish a Geographic Classification Review Board to consider the direct appeals of hospitals for a change in classification from rural to urban, or from one urban area to another urban area. Modifies the rules for adjusting values as a result of reclassification of a county under either the OBRA 87 provision or the new appeal procedure.

Public Law 101-508: Provides that if including wages of all redesignated hospitals in the wage index of the MSA to which they are redesignated reduces the MSA's wage index by more than 1 percentage point, then the original wage index (calculated without the wages of the redesignated hospitals) is applied to hospitals in the

MSA. Redesignated hospitals would receive a wage index combining their wages plus the wages of the MSA to which they were redesignated. Extends the due date for initial applications for reclassification submitted to the Geographic Classification Review Board until November 6, 1990, and clarifies the Secretary's ability to review decisions of the Board.

Payments for capital-related costs

Public Law 98-21: Provided that capital-related costs (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from the prospective payment system until no earlier than October 1, 1987, and are paid for on a reasonable cost basis. This legislation also required the Secretary to report to Congress within 18 months of enactment (October 1984) on methods and proposals by which capital costs can be included in the prospective payment rates. In March 1986, HHS submitted a report to Congress on incorporating capital costs in the prospective payment rates.

Public Law 98-369: Provided that, in the case where funds are borrowed for the purchase of used assets (change of ownership), the interest expense allowable to the new owner may not exceed the amount that would be incurred by borrowing funds equal to the depreciated value of the assets on the seller's books (i.e., without revaluation). Also provided that the return on equity capital on assets purchased from a previous owner (change of ownership) is limited to the amount that would be payable if the return were calculated on the depreciated value of the assets on the previous owner's books at the time of the sale.

Public Law 99-272: Provided that payments to proprietary hospitals for a return on equity (ROE) are separated from payments for other capital costs and phased out as follows: for hospital cost reporting periods beginning in fiscal year 1987, payment will equal 75 percent of the otherwise allowable ROE amount; for fiscal year 1988, 50 percent; for fiscal year 1989, 25 percent; and for fiscal year 1990 and thereafter, no ROE payments will be made.

Public Law 99-509: Reduced payment amounts for capital-related costs by 3.5 percent for portions of cost-reporting periods in fiscal year 1987, 7 percent for fiscal year 1988, and 10 percent for fiscal year 1989. The legislation exempts sole community hospitals from capital-related payment reductions and regulations for 3 years. It also clarifies that the HHS Secretary may incorporate capital-related costs, on a budget neutral basis into PPS, effective October 1, 1987.

Public Law 100-119 (the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987): Prohibited the Secretary from implementing published final regulations incorporating payments for capital costs into the DRG payment rates for fiscal year 1988, froze the capital payment reduction at the fiscal year 1987 level (3.5 percent), and delayed the phaseout of ROE payments to proprietary hospitals, for the period from October 1, to November 20, 1987. On November 21, 1987, the capital payment reduction reverted to the 7 percent level established for fiscal year 1988 in OBRA 1986, and the phaseout of ROE payments resumed.

Public Law 100-203: Increased the capital payment reduction to 12 percent for fiscal year 1988, effective on January 1, 1988, and 15 percent in fiscal year 1989. This legislation also prohibits the Secretary from incorporating payment of capital related costs into the PPS payment rates before October 1, 1991. However, the Secretary is required to make payments for capital related costs on a per case, prospective basis beginning on October 1, 1991. The methods to be used in making prospectively determined capital payments are generally left to the discretion of the Secretary. In addition, OBRA 1987 requires ProPAC to undertake a study and report to Congress by May 1, 1988, on the suitability and feasibility of linking payment for capital related costs to hospital occupancy rates.

Public Law 101-239: Extends the 15 percent capital-related payment reduction for portions of cost reporting periods or discharges occurring beginning on January 1, 1990 and continuing through the remainder of fiscal year 1990. For the period between October 1, 1989 and December 31, 1989, hospitals will receive 100 percent of capital costs, subject to the Gramm-Rudman-Hollings budget sequester reduction of 2.1 percent of total Medicare payments in effect from October 16 through December 31.

Public Law 101-508: Extends the 15 percent capital-related payment reduction for portions of cost reporting periods or discharges occurring in fiscal year 1991. For fiscal years 1992-1995, requires that aggregate payments to PPS hospitals would be reduced by an amount that equals a 10-percent reduction in capital payments based on reasonable cost. Rural primary care hospitals and sole community hospitals are exempt from the capital payment reduction in fiscal year 1991.

Additional sources of information

Prospective Payment Assessment Commission. Report and recommendations to the Secretary, U.S. Department of Health and Human Services. March 1, 1990. [Washington] 1990. 118 p.

———. Medicare prospective payment and the American health care system: report to the Congress. [Washington] June 1990. 110 p.

———. 1990 adjustment to the Medicare prospective payment system: report to the Congress. [Washington] November 1989. 36 p.

———. Medicare: Indirect Medical Education Adjustment. ProPAC Technical Report. Washington, July 1989.

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health. Fiscal year 1991 reconciliation: ProPAC report on the fiscal year 1991 budget. Hearing, 101st Congress, 2d Session. February 28, 1990.

———. Reimbursement under the Medicare program for hospital capital expenses. Hearing, 101st Congress, 1st Session on H.R. 712. March 13, 1989. Washington, 1989. 130 p.

———. Fiscal year 1990 budget issues relating to hospital payment under Part A of the Medicare program. Hearing, 101st Congress, 1st Session. March 1, 1989. Washington, 1989. 194 p.

U.S. Congress. House. Committee on Government Operations. Human Resources and Intergovernmental Relations Subcommittee. Quality of care in the Medicare program. Hearing, 101st Congress, 1st Session. March 13, 1989. Washington, 1989. 309 p.

U.S. Congress. House. Committee on the Budget. Task Force on Human Resources. Health care issues for fiscal year 1990. Hearing, 101st Congress, 1st Session. March 7, 1989. Washington, 1989. 173 p.

U.S. Congress. Senate. Committee on Finance. Medicare reimbursement to rural hospitals. Hearing, 101st Congress, 1st Session. May 4, 1989. Washington, 1989. 193 p.

———. Fiscal year 1990 budget issues relating to payment of inner-city and rural hospitals under Part A of the Medicare program. Hearing, 101st Congress, 1st Session. May 15, 1989. Washington, 1989. 239 p.

U.S. Congress. Office of Technology Assessment. Medicare's prospective payment system: strategies for evaluating cost, quality, and medical technology. [Washington] U.S. Government Printing Office, October 1985. 232 p. (OTA-H-262)

U.S. Department of Health and Human Services. Review of the impact of outlier and transfer payment policy upon rural hospitals. Report to Congress. [Washington] May 1988. 70 p.

———. Reimbursement of rural referral centers under the Medicare prospective payment system. Report to Congress. [Washington] Feb. 1988. 100 p.

———. Studies of urban-rural and related geographical adjustments in the Medicare prospective payment system. [Washington] Dec. 1987. 149 p.

———. Reimbursement of sole community hospitals under Medicare's prospective payment system. Report to Congress. [Washington] Dec. 1987. 85 p.

———. Impact of the Medicare Hospital Prospective Payment System 1986 Annual Report. Report to Congress. Washington, May 1989.

U.S. Department of Health and Human Services. Office of Inspector General. Office of Analysis and Inspections. Hospital closure: 1987. Washington, May 1989.

———. National DRG validation study: Special report on coding accuracy. [Washington] February 1988. 17 p. (Audit Control No. OAI-12-88-01010)

———. National DRG validation study: Special report on premature discharges. [Washington] February 1988. 27 p. (Audit Control No. OAI-05-88-00740)

U.S. General Accounting Office. Health care facilities: capital construction expenditures by State; fact sheet for the chairman. Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives. [Washington] U.S. Government Printing Office, August 1986. 15 p. (GAO/HRD-86-1345FS)

———. Medicare: Alternatives for paying hospital capital costs; report to the chairman. Subcommittee on Health, Committee on Ways and Means, House of Representatives. [Washington] U.S. Government Printing Office, August 1986. 73 p. (GAO/HRD-86-93)

———. Medicare: Reviews of quality of care at participating hospitals; report to the administrator, Health Care Financing Administration. [Washington] U.S. Government Printing Office, September 1986. 11 p. (GAO/HRD-86-139)

———. Past overuse of intensive care services inflates hospital payments; report to the Secretary of Health and Human Services. [Washington] U.S. Government Printing Office, March 1986. 96 p. (GAO/HRD-85-74)

———. Medicare: Number of rural hospitals terminating participation since the program began; report to the Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate. [Washington] U.S. Govt. Print. Off., 1988. 7 p. (GAO/HRD-88-46)

———. Medicare: Indirect medical education payments are too high; report to congressional committees. [Washington] U.S. Govt. Print. Off., 1989. 58 p. (GAO/HRD-89-33)

U.S. Congressional Budget Office. Setting Medicare's Indirect Teaching Adjustment for Hospitals. Washington, May 1989. 28 p.

U.S. Library of Congress. Congressional Research Service. Hospital capital cost reimbursement under Medicare [by] Julian Pettengill and Joseph A. Cislowski. [Washington] 1986. 44 p. CRS Report 86-598 EPW.

———. Medicare, Medicaid, and other health provisions of the Consolidated Budget Reconciliation Act of 1985 (P.L. 99-272 (known as COBRA)) [by] Jennifer O'Sullivan [Washington] 1986. 128 p. CRS Report 86-196 EPW.

———. Medicare, and Medicaid provisions of the Deficit Reduction Act of 1984 (P.L. 98-369) [by] Jennifer O'Sullivan. [Washington] 1985. 94 p. CRS Report 85-27 EPW.

———. Medicare: Prospective Payments for Inpatient Hospital Services [by] Celinda Franco. [Washington] 1987. (Updated regularly) CRS Issue Brief 87180.

———. Medicare: Recalculating payment rates under the prospective payment system, by Mark Merlis. [Washington] 1987. CRS Report 87-574 EPW.

———. Medicare's prospective payment system: The 98th and 99th Congresses, by Joseph A. Cislowski and Janet P. Lundy. [Washington] Oct. 29, 1987. CRS Report 87-862 EPW.

———. Medicare's prospective payment system: An analysis of the financial risk of outlier cases. [by] Julian Pettengill, Michael O'Grady, and Rich Rimkunas. [Washington] 1987. 217 p. CRS Report 87-877 EPW.

———. Rural hospitals, [by] Mark Merlis. Washington, 1989. 108 p. CRS Report 89-296 EPW.

———. Medicare: Payment for Hospital Capital Costs [by] Mark Merlis. [Washington] 1991. (Updated regularly) CRS Issue Brief 91028.

———. Medicare: Fiscal year 1992 budget, [by] Celinda Franco and Kathleen King. Washington, 1991. 15 p. (Updated regularly) CRS Issue Brief 91032.

TABLE 20.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX (Taylor, TX)	.9238
Aguadilla, PR (Aguada, PR, Aguadilla, PR, Isabella, PR, Moca, PR)	.4577
Akron, OH (Portage, OH, Summit, OH)	.9459
Albany, GA (Dougherty, GA, Lee, GA)	.8066
Albany-Schenectady-Troy, NY (Albany, NY, Greene, NY, Montgomery, NY, Rensselaer, NY, Saratoga, NY, Schenectady, NY)	.8940
Albuquerque, NM (Bernalillo, NM)	1.0144
Alexandria, LA (Rapides, LA)	.8292
Allentown-Bethlehem, PA-NJ (Warren, NJ, Carbon, PA, Lehigh, PA, Northampton, PA)	.9865
Altoona, PA (Blair, PA)	.9257
Amarillo, TX (Potter, TX, Randall, TX)	.8756
Anaheim-Santa Ana, CA (Orange, CA)	1.2009
Anchorage, AK	1.4204
Anderson, IN Madison, IN	.9602
Anderson, SC	.7272
Ann Arbor, MI (Washtenaw, MI)	1.1406
Anniston, AL (Calhoun, AL)	.7947
Appleton-Oshkosh-Neenah, WI (Calumet, WI, Outagamie, WI, Winnebago, WI)	.9197
Arecibo, PR (Arecibo, PR, Camuy, PR, Hatillo, PR, Quebradillas, PR)	.3961
Asheville, NC (Buncombe, NC)	.8756
Athens, GA (Clarke, GA, Jackson, GA, Madison, GA, Oconee, GA)	.8225
Atlanta, GA (Barrow, GA, Butts, GA, Cherokee, GA, Clayton, GA, Cobb, GA, Coweta, GA, De Kalb, GA, Douglas, GA, Fayette, GA, Forsyth, GA, Fulton, GA, Gwinnett, GA, Henry, GA, Newton, GA, Paulding, GA, Rockdale, GA, Spalding, GA, Walton, GA)	.9615
Atlantic City, NJ (Atlantic City, Cape May, NJ)	1.0527
Augusta, GA-SC (Columbia, GA, McDuffie, GA, Richmond, GA, Aiken, SC)	.9419
Aurora-Elgin, IL (Kane, IL, Kendall, IL)	.9684
Austin, TX (Hays, TX, Travis, TX, Williamson, TX)	.9618
Bakersfield, CA (Kern, CA)	1.0889
Baltimore, MD (Anne Arundel, MD, Baltimore, MD, Baltimore City, MD, Carroll, MD, Harford, MD, Howard, MD, Queen Annes, MD)	1.0176
Bangor, ME (Penobscot, ME)	.9082
Baton Rouge, LA (Ascension, LA, East Baton Rouge, LA, Livingston, LA, West Baton Rouge, LA)	.9107
Battle Creek, MI (Calhoun, MI)	.9484
Beaumont-Port Arthur, TX (Hardin, TX, Jefferson, TX, Orange, TX)	.9623
Beaver County, PA	1.0185
Bellingham, WA (Whatcom, WA)	1.0517
Benton Harbor, MI Berrien, MI	.8157
Bergen-Passaic, NJ	1.0316
Billings, MT (Yellowstone, MT)	.9343
Biloxi-Gulfport, MS (Hancock, MS, Harrison, MS)	.8078
Binghamton, NY (Broome, NY, Tioga, NY)	.9278
Birmingham, AL (Blount, AL, Jefferson, AL, Saint Clair, AL, Shelby, AL, Walker, AL)	.8787
Bismarck, ND (Burleigh, ND, Morton, ND)	.8830
Bloomington, IN (Monroe, IN)	.8656
Bloomington-Normal, IL (McLean, IL)	.8676
Boise City, ID (Ada, ID)	.9776
Boston-Lawrence-Salem-Lowell-Brockton, MA (Essex, MA, Middlesex, MA, Norfolk, MA, Plymouth, MA, Suffolk, MA)	1.1833
Boulder-Longmont, CO (Boulder, CO)	1.0169
Bradenton, FL (Manatee, FL)	.9280
Brazoria, TX	.9174
Bremerton, WA (Kitsap, WA)	.9554
Bridgeport-Stamford-Norwalk-Danbury, CT (Fairfield, CT)	1.2056
Brownsville-Harlingen, TX (Cameron, TX)	.8618

TABLE 20.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Bryan-College Station, TX (Brazos, TX)	.9507
Buffalo, NY (Erie, NY)	.8926
Burlington, NC (Alamance, NC)	.8002
Burlington, VT (Chittenden, VT, Grand Isle, VT)	.9377
Caguas, PR (Caguas, PR, Gurabo, PR, San Lorenz, PR, Aguas Buenas, PR, Cayey, PR, Cidra, PR)	.4488
Canton, OH (Carroll, OH, Stark, OH)	.8721
Casper, WY (Natrona, WY)	.8908
Cedar Rapids, IA (Linn, IA)	.8925
Champaign-Urbana-Rantoul, IL	.8762
Charleston, SC (Berkeley, SC, Charleston, SC, Dorchester, SC)	.8348
Charleston, WV (Kanawha, WV, Putnam, WV)	.9712
Charlotte-Gastonia-Rock Hill, NC–SC (Cabarrus, NC, Gaston, NC, Lincoln, NC, Mecklengburg, NC, Rowan, NC, Union, NC, York, SC)	.9505
Charlottesville, VA (Albermarle, VA, Charlottesville City, VA, Fluvanna, VA, Greene, VA)	.9634
Chattanooga, TN–GA (Catoosa, GA, Dade, GA, Walker, GA, Hamilton, TN, Marion, TN, Sequatchie, TN)	.9216
Cheyenne, WY (Laramie, WY)	.7924
Chicago, IL (Cook, IL, Du Page, IL, McHenry, IL)	1.0538
Chico, CA (Butte, CA)	1.0556
Cincinnati, OH–KY–IN (Dearborn, IN, Boone, KY, Campbell, KY, Kenton, KY, Clermont, OH, Hamilton, OH, Warren, OH)	.9840
Clarksville-Hopkinsville, TN–KY (Christian, KY, Montgomery, TN)	.7334
Cleveland, OH (Cuyahoga, OH, Geauga, OH, Lake, OH, Medina, OH)	1.0760
Colorado Springs, CO (El Paso, CO)	.9836
Columbia,MO (Boone, MO)	.9525
Columbia, SC (Lexington, SC, Richland, SC)	.8958
Columbus, GA–AL (Russell, AL, Chattanoochee, GA, Muscogee, GA)	.7497
Columbus, OH (Delaware, OH, Fairfield, OH, Franklin, OH, Licking, OH, Madison, OH, Pickaway, OH, Union, OH)	.9692
Corpus Christi, TX (Nueces, TX, San Patricio, TX)	.8611
Cumberland, MD–WV (Allegeny, MD, Mineral, WV)	.8204
Dallas, TX (Collin, TX, Dallas, TX, Denton, TX, Ellis, TX, Kaufman, TX, Rockwall, TX)	.9438
Danville, VA (Danville City, VA, Pittsylvania, VA)	.7521
Davenport-Rock Island-Moline, IA–IL (Scott, IA, Henry, IL, Rock Island, IL)	.8487
Dayton-Springfield, OH (Clark, OH, Greene, OH, Miami, OH, Montgomery, OH)	.9683
Daytona Beach, FL (Volusia, FL)	.8961
Decatur, AL (Lawrence, AL, Limestone, AL, Morgan, AL)	.7502
Decatur, IL (Macon, IL)	.8302
Denver, CO (Adams, CO, Arapahoe, CO, Denver, CO, Douglas, CO, Jefferson, CO)	1.0779
Des Moines, IA (Dallas, IA, Polk, IA, Warren, IA)	.9189
Detroit, MI (Lapeer, MI, Livingston, MI, Macomb, MI, Monroe, MI, Oakland, MI, Saint Clair, MI, Wayne, MI)	1.0841
Dothan, AL (Dale, AL, Houston, AL)	.7570
Dubuque, IA	.8391
Duluth, MN–WI (St. Louis, MN, Douglas, WI)	.9536
Eau Claire, WI (Chippewa, WI, Eau Claire, WI)	.8494
El Paso, TX	.8731
Elkhart-Goshen, IN (Elkhart, IN)	.8966
Elmira, NY (Chemung, NY)	.8828
Enid, OK (Garfield, OK)	.8930
Erie, PA	.9173
Eugene-Springfield, OR (Lane, OR)	.9963
Evansville, IN–KY (Posey, IN, Vanderburgh, IN, Warrick, IN, Henderson, KY)	.9294
Fargo-Moorhead, ND–MN (Clay, MN, Cass, ND)	.9726
Fayetteville, NC (Cumberland, NC)	.8312
Fayetteville-Springdale, AR (Washington, AR)	.8006
Flint, MI (Genesee, MI, Shiawassee, MI)	1.1566
Florence, AL (Colbert, AL, Lauderdale, AL)	.7694
Florence, SC	.8445
Fort Collins-Loveland, CO (Larimor, CO)	1.0258
Fort Lauderdale-Hollywood-Pompano Beach, FL (Broward, FL)	1.0377
Fort Myers-Cape Coral, FL (Lee, FL)	.9818

TABLE 20.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Fort Pierce, FL (Martin, FL, St. Lucie, FL)	1.1063
Fort Smith, AR–OK (Crawford, AR, Sebastian, AR, Sequoyah, OK)	.7947
Fort Walton Beach, FL (Okaloosa, FL)	.8934
Fort Wayne, IN (Allen, IN, De Kalb, IN, Whitley, IN)	.8919
Fort Worth-Arlington, TX (Johnson, TX, Parker, TX, Tarrant, TX)	.9506
Fresno, CA	1.0758
Gadsden, AL (Etowah, AL)	.8215
Gainesville, FL (Alachua, FL, Bradford, FL)	.8816
Galveston-Texas City, TX (Galveston, TX)	.9439
Gary-Hammond, IN (Lake, IN, Porter, IN)	.9872
Glens Falls, NY (Warren, NY, Washington, NY)	.9249
Grand Forks, ND	.9596
Grand Rapids, MI (Kent, MI, Ottawa, MI)	.9902
Great Falls, MT (Cascade, MT)	1.0011
Greeley, CO (Weld, CO)	.9376
Green Bay, WI (Brown, WI)	.9604
Greensboro-Winston-Salem-High Point, NC (Davidson, NC, Davie, NC, Forsyth, NC, Guilford, NC, Randolph, NC, Stokes, NC, Yadkin, NC)	.8769
Greenville-Spartanburg, SC (Greenville, SC, Pickens, SC, Spartanburg, SC)	.8921
Hagerstown, MD (Washington, MD)	.9176
Hamilton-Middletown, OH (Butler, OH)	.9403
Harrisburg-Lebanon-Carlisle, PA (Cumberland, PA, Dauphin, PA, Lebanon, PA, Perry, PA)	.9938
Hartford-Middletown-New Britain-Bristol, CT (Hartford, CT, Litchfield, CT, Middlesex, CT, Tolland, CT)	1.1940
Hickory, NC (Alexander, NC, Burke, NC, Catawba, NC)	.8759
Honolulu, HI	1.1603
Houma-Thibodaux, LA (Lafourche, LA, Terrebonne, LA)	.7191
Houston, TX (Fort Bend, TX, Harris, TX, Liberty, TX, Montgomery, TX, Waller, TX)	.9797
Huntington-Ashland, WV–KY–OH (Boyd, KY, Carter, KY, Greenup, KY, Lawrence, OH, Cabell, WV, Wayne, WV)	.9456
Huntsville, AL (Madison, AL)	.8852
Indianapolis, IN (Boone, IN, Hamilton, IN, Hancock, IN, Hendricks, IN, Johnson, IN, Marion, IN, Morgan, IN, Shelby, IN)	.9586
Iowa City, IA (Johnson, IA)	.9547
Jackson, MI	.9683
Jackson, MS (Hinds, MS, Madison, MS, Rankin, MS,)	.7748
Jackson, TN (Madison, TN)	.7926
Jacksonville, FL (Clay, FL, Duval, FL, Nassau, FL, St. Johns, FL)	.9069
Jacksonville, NC (Onslow, NC)	.7168
Jamestown-Dunkirk, NY	.7750
Janesville-Beloit, WI (Rock, WI)	.8482
Jersey City, NJ (Hudson, NJ)	1.0547
Johnson City-Kingsport-Bristol, TN–VA (Carter, TN, Hawkins, TN, Sullivan, TN, Unicoi, TN, Washington, TN, Bristol City, VA, Scott, VA, Washington, VA)	.8685
Johnstown, PA (Cambria, PA, Somerset, PA)	.9085
Joliet, IL (Grundy, IL, Will, IL)	1.0299
Joplin, MO (Jasper, MO, Newton, MO)	.7896
Kalamazoo, MI	1.1733
Kankakee, IL	.8505
Kansas City, KS–MO (Johnson, KS, Leavenworth, KS, Miami, KS, Wyandotte, KS, Cass, MO, Clay, MO, Jackson, MO, Lafayette, MO, Platte, MO, Ray, MO)	.9607
Kenosha, WI	.8872
Killeen-Temple, TX (Bell, TX, Coryell, TX)	1.1317
Knoxville, TN (Anderson, TN, Blount, TN, Grainger, TN, Jefferson, TN, Knox, TN, Sevier, TN, Union, TN)	.8667
Kokomo, IN (Howard, IN, Tipton, IN)	.9976
LaCrosse, WI	.8974
Lafayette, LA (Lafayette, LA, St. Martin, LA)	.8243
Lafayette, IN (Tippecanoe, IN)	.8449
Lake Charles, LA (Calcasieu, LA)	.8391
Lake County, IL (Lake, IL)	1.0013
Lakeland-Winter Haven, FL (Polk, FL)	.8187
Lancaster, PA (Lancaster, PA)	.9276

TABLE 20.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Lansing-East Lansing, MI (Clinton, MI, Eaton, MI, Ingham, MI)	1.0243
Laredo, TX (Webb, TX)	.7292
Las Cruces, NM (Dona Ana, NM)	.7925
Las Vegas, NV (Clark, NV)	1.0652
Lawrence, KS (Douglas, KS)	.8954
Lawton, OK (Comanche, OK)	.8405
Lewiston-Auburn, ME (Androscoggin, ME)	.9075
Lexington-Fayette, KY (Bourbon, KY, Clark, KY, Fayette, KY, Jessamine, KY, Scott, KY, Woodford, KY)	.8463
Lima, OH (Allen, OH, Auglaize, OH)	.8108
Lincoln, NE (Lancaster, NE)	.8973
Little Rock-North Little Rock, AR (Faulkner, AR, Lonoke, AR, Pulaski, AR, Saline, AR)	.8437
Longview-Marshall, TX (Gregg, TX, Harrison, TX)	.8708
Lorain-Elyria, OH (Lorain, OH)	.8968
Los Angeles-Long Beach, CA (Los Angeles, CA)	1.2379
Louisville, KY–IN (Clark, IN, Floyd, IN, Harrison, IN, Bullitt, KY, Jefferson, KY, Oldham, KY, Shelby, KY)	.9110
Lubbock, TX	.8807
Lynchburg, VA (Amherst, VA, Campbell, VA, Lynchburg City, VA)	.8561
Macon-Warner Robins, GA (Bibb, GA, Houston, GA, Jones, GA, Peach, GA)	.8821
Madison, WI (Dane, WI)	1.0331
Manchester-Nashua, NH (Hillsborough, NH, Merrimack, NH)	1.0261
Mansfield, OH (Richland, OH)	.8409
Mayaguez, PR (Anasco, PR, Cabo Rojo, PR, Hormigueros, PR, Mayaguez, PR, San German, PR)	.4781
McAllen-Edinburg-Mission, TX (Hidalgo, TX)	.7152
Medford, OR (Jackson, OR)	1.0065
Melbourne-Titusville, FL (Brevard, FL)	.9218
Memphis, TN–AR–MS (Crittened, AR, De Soto, MS, Shelby, TN Tipton, TN)	.9078
Merced, CA	1.0332
Miami-Hialeah, FL (Dade, FL)	1.0209
Middlesex-Somerset-Hunterdon, NJ (Hunterdon, NJ, Middlesex, NJ, Somerset, NJ)	1.0421
Midland, TX	1.0397
Milwaukee, WI (Milwaukee, WI, Ozaukee, WI, Washington, WI, Waukesha, WI)	.9738
Minneapolis-St. Paul, MN–WI (Anoka, MN, Carver, MN, Chisago, MN, Dakota, MN, Hennepin, MN, Isanti, MN, Ramsey, MN, Scott, MN, Washington, MN, Wright, MN, St. Croix, WI)	1.0839
Mobile, AL (Baldwin, AL, Mobile, AL)	.8336
Modesto, CA (Stanislaus, CA)	1.1600
Monmouth-Ocean, NJ (Monmouth, NJ, Ocean, NJ)	.9919
Monroe, LA (Ouachita, LA)	.7879
Montgomery, AL (Autauga, AL, Elmore, AL, Montgomery, AL)	.7754
Muncie, IN (Delaware, IN)	.8084
Muskegon, MI	.9586
Naples, FL (Collier, FL)	1.0344
Nashville, TN (Cheatham, TN, Davidson, TN, Dickson, TN, Robertson, TN, Rutherford, TN, Sumner, TN, Williamson, TN, Wilson, TN)	.9416
Nassau-Suffolk, NY (Nassau, NY, Suffolk, NY)	1.2984
New Bedford-Fall River-Attleboro, MA (Bristol, MA)	.9951
New Haven-Waterbury-Meriden, CT (New Haven, CT)	1.2119
New London-Norwich, CT (New London, CT)	1.1594
New Orleans, LA (Jefferson, LA, Orleans, LA, St. Bernard, LA, St. Charles, LA, St. John The Baptist, LA, St. Tammany, LA)	.8918
New York, NY (Bronx, NY, Kings, NY, New York City, NY, Putnam, NY, Queens, NY, Richmond, NY, Rockland, NY, Westchester, NY)	1.3487
Newark, NJ (Essex, NJ, Morris, NJ, Sussex, NJ, Union, NJ)	1.1254
Niagara Falls, NY	.8398
Norfolk-Virginia Beach-Newport News, VA (Chesapeake City, VA, Gloucester, VA, Hampton City, VA, James City Co., VA, Newport News City, VA, Norfolk City, VA, Poquoson, VA, Portsmouth City, VA, Suffolk City, VA, Virginia Beach City, VA, Williamsburg City, VA, York, VA)	.8532
Oakland, CA (Alameda, CA, Contra Costa, CA)	1.4311
Ocala, FL (Marion, FL)	.8631
Odessa, TX (Ector, TX)	1.0838

TABLE 20.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Oklahoma City, OK (Canadian, OK, Cleveland, OK, Logan, OK, McClain, OK, Oklahoma, OK, Pottawatomie, OK)	.9163
Olympia, WA (Thurston, WA)	1.1023
Omaha, NE–IA (Pottawattamie, IA, Douglas, NE, Sarpy, NE, Washington, NE)	.9007
Orange County, NY (Orange, NY)	.9672
Orlando, FL (Orange, FL, Osceola, FL, Seminole, FL)	.9625
Owensboro, KY (Daviess, KY)	.8131
Oxnard-Ventura, CA (Ventura, CA)	1.2333
Panama City, FL (Bay, FL)	.8650
Parkersburg-Marietta, WV–OH (Washington, OH, Wood, WV)	.8556
Pascugoula, MS (Jackson, MS)	.8773
Pensacola, FL(Escambia, FL, Santa Rosa, FL)	.8641
Peoria, IL (Peoria, IL, Tazewell, IL, Woodford, IL)	.8727
Philadelphia, PA–NJ (Burlington, NJ, Camden, NJ, Gloucester, NJ, Bucks, PA, Chester, PA, Delaware, PA, Montgomery, PA, Philadelphia, PA)	1.0973
Phoenix, AZ (Maricopa, AZ)	1.0449
Pine Bluff, AR (Jefferson, AR)	.7888
Pittsburgh, PA (Allegheny, PA, Fayette, PA, Washington, PA, Westmoreland, PA)	1.0147
Pittsfield, MA (Berkshire, MA)	1.0804
Ponce, PR (Juana Diaz, PR, Ponce, PR)	.4610
Portland, ME (Cumberland, ME, Sagadahoc, ME, York, ME)	.9310
Portland, OR (Clackamas, OR, Multnomah, OR, Washington, OR, Yamhill, OR)	1.1587
Portsmouth-Dover-Rochester, NH (Rockingham, NH, Strafford, NH)	1.0100
Poughkeepsie, NY (Dutchess, NY)	1.0468
Providence-Pawtucket-Woonsocket, RI (Bristol, RI, Kent, RI, Newport, RI, Providence, RI, Washington, RI)	1.0638
Provo-Orem, UT (Utah, UT)	1.0250
Pueblo, CO (Pueblo, CO)	.8739
Racine, WI	.8867
Raleigh-Durham, NC (Durham, NC, Franklin, NC, Orange, NC, Wake, NC)	.9484
Rapid City, SD (Pennington, SD)	.8417
Reading, PA (Berks, PA)	.8805
Redding, CA (Shasta, CA)	1.0570
Reno, NV (Washoe, NV)	1.1641
Richland-Kennewick, WA (Benton, WA, Franklin, WA)	.9421
Richmond-Petersburg, VA (Charles City Co., VA, Chesterfield, VA, Colonial Heights City, VA, Dinwiddie, VA, Goochland, VA, Hanover, VA, Henrico, VA, Hopewell City, VA, New Kent, VA, Petersburg City, VA, Powhatan, VA, Prince George, VA, Richmond City, VA)	.9436
Riverside-San Bernardino, CA (Riverside, CA, San Bernardino, CA)	1.1174
Roanoke, VA (Botetourt, VA, Roanoke, VA, Roanoke City, VA, Salem City, VA)	.8301
Rochester, MN (Olmsted, MN)	1.1051
Rochester, NY (Livingston, NY, Monroe, NY, Ontario, NY, Orleans, NY, Wayne, NY)	.9729
Rockford, IL (Boone, IL Winnebago, IL)	.9301
Sacramento, CA (Eldorado, CA, Placer, CA, Sacramento, CA, Yolo, CA)	1.2257
Saginaw-Bay City-Midland, MI (Bay, MI, Midland, MI, Saginaw, MI)	1.0138
St. Cloud, MN (Benton, MN, Sherburne, MN, Stearns, MN)	.9439
St. Joseph, MO (Buchanan, MO)	.9432
St. Louis, MO–IL (Clinton, IL, Jersey, IL, Madison, IL, Monroe, IL, St. Clair, IL, Franklin, MO, Jefferson, MO, St. Charles, MO, St. Louis, MO, St. Louis City, MO)	.9407
Salem, OR (Marion, OR, Polk, OR)	1.0466
Salinas-Seaside-Monterey, CA (Monterey, CA)	1.3067
Salt Lake City-Ogden, UT (Davis, UT, Salt Lake, UT, Weber, UT)	.9952
San Angelo, TX (Tom Green, TX)	.8155
San Antonio, TX (Bexar, TX, Comal, TX, Guadalupe, TX)	.8450
San Diego, CA	1.1862
San Francisco, CA (Marin, CA, San Francisco, CA, San Mateo, CA)	1.4567
San Jose, CA (Santa Clara, CA)	1.4677
San Juan, PR (Barcelona, PR, Bayoman, PR, Canovanas, PR, Carolina, PR, Catano, PR. Corozal, PR, Dorado, PR, Fajardo, PR, Florida, PR, Guaynabo, PR, Humacao, PR, Juncos, PR, Los Piedras, PR, Loiza, PR, Luguillo, PR, Manati, PR, Naranjito, PR, Rio Grande, PR, San Juan, PR, Toa Alta, PR, Toa Baja, PR, Trojillo Alto, PR, Vega Alta, PR, Vega Baja, PR)	.4997
Santa Barbara-Santa Maria-Lompoc, CA (Santa Barbara, CA)	1.1792

TABLE 20.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Santa Cruz, CA	1.2809
Santa Fe, NM (Los Alamos, NM, Santa Fe, NM)	.9157
Santa Rosa-Petaluma, CA (Sonoma, CA)	1.2968
Sarasota, FL	.9800
Savannah, GA (Chatham, GA, Effingham, GA)	.8344
Scranton-Wilkes Barre, PA (Columbia, PA Lackawanna, PA, Luzerne. PA, Monroe, PA, Wyoming, PA)	.8970
Seattle, WA (King, WA, Snohomish, WA)	1.0892
Sharon, PA (Mercer, PA)	.9079
Sheboygan, WI	.8889
Sherman-Denison, TX (Grayson, TX)	.9107
Shreveport, LA (Bossier, LA, Caddo, LA)	.9318
Sioux City, IA–NE (Woodbury, IA, Dakota, NE)	.8521
Sioux Falls, SD (Minnehaha, SD)	.8850
South Bend-Mishawaka, IN (St. Joseph, IN)	1.0087
Spokane, WA	1.0713
Springfield, IL (Menard, IL, Sangamon, IL)	.9314
Springfield, MO (Christian, MO, Greene, MO)	1.0336
Springfield, MA (Hampden, MA, Hampshire, MA)	.8098
State College, PA (Centre, PA)	.9921
Steubenville-Weirton, OH–WV (Jefferson, OH, Brooke, WV, Hancock, WV)	.8729
Stockton, CA (San Joaquin, CA)	1.1635
Syracuse, NY (Madison, NY, Onondaga, NY, Oswego, NY)	.9580
Tacoma, WA (Pierce, WA)	1.0338
Tallahassee, FL (Gadsden, FL, Leon, FL)	.9238
Tampa-St. Petersburg-Clearwater, FL (Hernando, FL, Hillsborough, FL, Pasco, FL, Pinellas, FL)	.9206
Terre Haute, IN (Clay, IN, Vigo, IN)	.8775
Texarkana-TX-Texarkana, AR (Miller, AR, Bowie, TX)	.7907
Toledo, OH (Fulton, OH, Lucas, OH, Wood, OH)	1.0107
Topeka, KS (Shawnee, KS)	.9285
Trenton, NJ	1.0058
Tucson, AZ (Pima, AZ)	.9610
Tulsa, OK (Creeks, OK, Osage, OK, Rogers, OK, Tulsa, OK, Wagoner, OK)	.8412
Tuscaloosa, AL	.8538
Tyler, TX (Smith, TX)	.9650
Utica-Rome, NY (Herkimer, NY, Oneida, NY)	.8340
Vallejo-Fairfield-Napa, CA (Napa, CA, Solano, CA)	1.3229
Vancouver, WA (Clark, WA)	1.0820
Victoria, TX	.9011
Vineland-Millville-Bridgeton, NJ (Cumberland, NJ)	.9779
Visalia-Tulare-Porterville, CA (Tulare, CA)	1.0413
Waco, TX (McLennan, TX)	.7830
Washington, D.C.–MD–VA (District of Columbia, DC, Calvert, MD, Charles, MD, Frederick, MD, Montgomery, MD, Prince Georges, MD, Alexandria City, VA, Arlington, VA, Fairfax, VA, Fairfax City, VA, Falls Church City, VA, Loudoun, VA, Manassas City, VA, Manassas Park City, VA, Prince William, VA, Stafford, VA)	1.0962
Waterloo-Cedar Falls, IA (Black Hawk, IA, Bremer, IA)	.8659
Wausau, WI (Marathan, WI)	.9767
West Palm Beach-Boca Raton-Delray Beach, FL (Palm Beach, FL)	1.0155
Wheeling, WV–OH (Belmont, OH, Marshall, WV, Ohio, WV)	.7849
Wichita, KS (Butler, KS, Harvey, KS, Sedgwick, KS)	.9829
Wichita Falls, TX (Wichita, TX)	.8188
Williamsport, PA (Lycoming, PA)	.8874
Wilmington, DE–NJ–MD (New Castle, DE, Cecil, MD, Salem, NJ)	1.0890
Wilmington, NC (New Hanover, NC)	.8729
Worcester-Fitchburg-Leominster, MA (Worcester, MA)	1.0836
Yakima, WA	1.0131
York, PA (Adams, PA, York, PA)	.9039
Youngstown-Warren, OH (Mahoning, OH, Trumball, OH)	.9885
Yuba City, CA (Sutter, CA, Yuba, CA)	1.0187
Yuma, AZ	.8902

Source: Federal Register, January 7, 1991.

TABLE 21.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index	Nonurban area	Wage index
Alabama	.7096	Nebraska	.7010
Alaska	1.3453	Nevada	.9721
Arizona	.8613	New Hampshire	.9565
Arkansas	.6980	New Jersey [1]	
California	1.0140	New Mexico	.8313
Colorado	.8425	New York	.8448
Connecticut	1.1929	North Carolina	.7865
Delaware	.8589	North Dakota	.7734
Florida	.8748	Ohio	.8431
Georgia	.7743	Oklahoma	.7415
Hawaii	.9637	Oregon	.9574
Idaho	.8970	Pennsylvania	.8656
Illinois	.7726	Puerto Rico	.4342
Indiana	.7763	Rhode Island [1]	
Iowa	.7522	South Carolina	.7626
Kansas	.7465	South Dakota	.7182
Kentucky	.7809	Tennessee	.7353
Louisiana	.7399	Texas	.7575
Maine	.8344	Utah	.9000
Maryland	.8077	Vermont	.9053
Massachusetts	1.1677	Virginia	.7820
Michigan	.8834	Virgin Islands [1]	
Minnesota	.8325	Washington	.9654
Mississippi	.6824	West Virginia	.8523
Missouri	.7227	Wisconsin	.8440
Montana	.8271	Wyoming	.8474

[1] All counties within the State are classified urban.

Source: Federal Register, January 7, 1991.

TABLE 22.—WAGE INDEX FOR RURAL COUNTIES WHOSE HOSPITALS ARE DEEMED URBAN—USING URBAN AREA WAGE INDEX

County	Urban area	Wage index
Macoupin Co., IL	St. Louis, MO-IL	.9407
Mason Co., IL	Peoria, IL	.8727
Clinton, IN	Lafayette, IN	.8449
Jefferson Co., KS	Topeka, KS	.9285
Allegan Co., MI	Grand Rapids, MI	.9902
Barry Co., MI	Battle Creek, MI	.9484
Shiawassee Co., MI	Flint, MI	1.1566
Clinton Co., MO	Kanasa City, MO-KS	.9607
Cherokee Co., SC	Greenville-Spartanburg, SC	.8921
Bedford Co., VA	Roanoke, VA	.8301
Fredericksburg City, VA	Washington, DC-MD-VA	1.0962
Jefferson Co., WI	Milwaukee, WI	.9736
Jefferson Co., WV	Washington, DC-MD-VA	1.0962
Walworth Co., WI	Milwaukee, WI	.9736

Source: Federal Register, January 7, 1991.

TABLE 23.—WAGE INDEX FOR RURAL COUNTIES WHOSE HOSPITALS ARE DEEMED URBAN—COMPUTED AS BEING COMBINED WITH THE URBAN AREA

County	Urban area	Wage index
Limestone Co., AL	Huntsville, AL	.8439
Marshall Co., AL	Huntsville, AL	.8439
Charlotte Co., FL	Sarasota, FL	.9496
Indian River Co., FL	Fort Pierce, FL	1.0333
Christian Co., IL	Springfield, IL	.9211
Henry Co., IN	Anderson, IN	.9439
Ionia Co., MI	Lansing-East Lansing, MI	1.1031
Lenawee Co., MI	Ann Arbor, MI	1.1241
Tuscoia Co., MI	Saginaw-Bay City-Midland, MI	1.0037
Van Buren Co., MI	Kalamazoo, MI	1.1478
Harnett Co., NC	Fayetteville, NC	.8067
Genesee Co., NY	Rochester, NY	.9605
Columbiana Co., OH	Beaver County, PA	.9087
Lawrence Co., PA	Beaver County, PA	.0987

Source: Federal Register, January 7, 1991.

TABLE 24.—WAGE INDEX FOR RURAL COUNTIES WHOSE HOSPITALS ARE DEEMED URBAN—USING STATEWIDE RURAL WAGE INDEX

County	Urban area	Wage index
Cass Co., MI	Benton Harbor, MI	.8834
Morrow Co., OH	Mansfield, OH	.8431
Van Wert Co., OH	Lima, OH	.8431

Source: Federal Register, January 7, 1991.

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC	Type	Title	Relative weighting factors 1987	Relative weighting factors 1990	Relative weighting factors 1991	1991 outlier threshold
1	1	Surg	Craniotomy age greater than 17 except for trauma.	3.5610	3.5670	3.3580	42
2	1	Surg	Craniotomy for trauma age greater than 17.	3.8111	4.1379	3.5485	41
3	1	Surg	Craniotomy age 0–17	2.9183	2.8830	2.8830	42
4	1	Surg	Spinal procedures	2.7296	2.6483	2.4532	40
5	1	Surg	Extracranial vascular procedures	1.6508	1.5214	1.5246	35
6	1	Surg	Carpal tunnel release	.4073	.4709	.4823	19

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
7	1	Surg	Periph and cranial nerve and other nerv syst proc with CC.	1.3866	3.1110	2.6823	41
8	1	Surg	Periph and cranial nerve and other nerv syst proc without CC.	.7464	.7355	.7451	32
9	1	Med	Spinal disorders and injuries	1.4235	1.4058	1.2229	36
10	1	Med	Nervous system neoplasms with CC	1.1322	1.2449	1.2765	37
11	1	Med	Nervous system neoplasms without CC	.9338	.7451	.7771	34
12	1	Med	Degenerative nervous system disorders	1.0001	.9391	.9256	36
13	1	Med	Multiple sclerosis and cerebellar ataxia	.9790	.8699	.8726	36
14	1	Med	Specific cerebrovascular disorders except TIA.	1.3143	1.2260	1.2212	36
15	1	Med	Transient ischemic attack and precerebral occlusions.	.6241	.6350	.6420	33
16	1	Med	Nonspecific cerebrovascular disorders with CC.	.9042	1.0949	1.0703	36
17	1	Med	Nonspecific cerebrovascular disorders without CC.	.6802	.6452	.6326	33
18	1	Med	Cranial and peripheral nerve disorders with CC.	.7566	.9640	.8749	35
19	1	Med	Cranial and peripheral nerve disorders without CC.	.6549	.5869	.5629	33
20	1	Med	Nervous system infection except viral meningitis.	1.4087	1.7817	1.8683	37
21	1	Med	Viral meningitis	1.3143	1.4190	1.4439	37
22	1	Med	Hypertensive encephalopathy	.7086	.6981	.7206	33
23	1	Med	Nontraumatic stupor and coma	1.1239	.8698	.8322	33
24	1	Med	Seizure and headache age greater than 17 with CC.	.7642	.9669	.9602	34
25	1	Med	Seizure and headache age greater than 17 without CC.	.5520	.5270	.5197	28
26	1	Med	Seizure and headache age 0–17	.6255	.7313	.8176	33
27	1	Med	Traumatic stupor and coma, coma greater than 1 HR.	1.5645	1.6124	1.3481	33
28	1	Med	Traumatic stupor and coma, coma greater than 1 HR age greater than 17 with CC.	.9422	1.2750	1.2060	35
29	1	Med	Traumatic stupor and coma, coma less than 1 HR age greater than 17 without CC.	.6462	.5730	.5674	32
30	1	Med	Traumatic stupor and coma, coma less than 1 HR age 0–17.	.3539	.3496	.3496	17
31	1	Med	Concussion age greater than 17 with CC.	.5381	.7007	.6933	33
32	1	Med	Concussion age greater than 17 without CC.	.4064	.4038	.4100	25
33	1	Med	Concussion age 0–17	.2457	.2427	.2427	9
34	1	Med	Other disorders of nervous system with CC.	.9761	1.2069	1.714	35
35	1	Med	Other disorders of nervous system without CC.	.7383	.5597	.5464	33
36	2	Surg	Retinal procedures	.7101	.6443	.6487	13
37	2	Surg	Orbital procedures	.6687	.7415	.7431	32
38	2	Surg	Primary iris procedures	.3963	.3550	.3614	17
39	2	Surg	Lens procedures with or without vitrectomy.	.5719	.4494	.4456	8
40	2	Surg	Extraocular procedures except orbit age greater than 17.	.4133	.4762	.4923	21

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
41	2	Surg	Extraocular procedures except orbit age 0–17.	.3657	.3613	.3613	7
42	2	Surg	Intraocular procedures retina, iris and lens.	.6542	.6305	.6202	16
43	2	Med	Hyphema	.3461	.3350	.3867	32
44	2	Med	Acute major eye infections	.6395	.6035	.5979	35
45	2	Med	Neurological eye disorders	.5407	.5454	.5850	29
46	2	Med	Other disorders of the eye age greater than 17 with CC.	.6009	.6495	.6701	33
47	2	Med	Other disorders of the eye age greater than 17 without CC.	.4187	.3539	.3608	28
48	2	Med	Other disorders of the eye age 0–17	.4018	.3969	.3969	30
49	3	Surg	Major head and neck procedures	2.8742	2.8633	2.3273	36
50	3	Surg	Sialoadenectomy	.7033	.6298	.6413	14
51	3	Surg	Salivary gland procedures except sialoadenectomy.	.5878	.5647	.5822	20
52	3	Surg	Cleft lip and palate repair	.6955	.8129	.7394	25
53	3	Surg	Sinus and mastoid procedures age greater than 17.	.6175	.6161	.6308	19
54	3	Surg	Sinus and mastoid procedures age 0–17.	.6889	.6806	.6806	22
55	3	Surg	Miscellaneous ear, nose and throat procedures.	.4342	.4879	.4905	13
56	3	Surg	Rhinoplasty	.4357	.4881	.4982	13
57	3	Surg	T&A proc, except tonsillectomy and/or adenoidectomy only, age greater than 17.	.7717	.9313	.8774	32
58	3	Surg	T&A proc, except tonsillectomy and/or adenoidectomy only, age 0–17.	.3097	.3060	.3060	4
59	3	Surg	Tonsillectomy and/or adenoidectomy only, age greater than 17.	.4130	.3878	.4192	12
60	3	Surg	Tonsillectomy and/or adenoidectomy only, age 0–17.	.2616	.2584	.2584	4
61	3	Surg	Myringotomy with tube insertion age greater than 17.	.4273	.6945	.7656	31
62	3	Surg	Myringotomy with tube insertion age 0–17.	.3089	.3052	.3052	5
63	3	Surg	Other ear, nose and throat O.R. procedures.	1.1618	1.1882	1.0111	33
64	3	Med	Ear, nose and throat malignancy	.9769	1.1762	1.0651	34
65	3	Med	Dysequilibrium	.4500	.4564	.4636	23
66	3	Med	Epistaxis	.4144	.4496	.4528	24
67	3	Med	Epiglottitis	.9363	.8589	.8478	33
68	3	Med	Otitis media and uri age greater than 17 with CC.	.6088	.7232	.7209	33
69	3	Med	Otitis media and uri age greater than 17 without CC.	.5040	5281	.5086	24
70	3	Med	Otitis media and uri age 0–17	.5251	.4589	.2830	13
71	3	Med	Laryngotracheitis	.6582	.7307	.7030	27
72	3	Med	Nasal trauma and deformity	.5216	.5528	.5547	32
73	3	Med	Other ear, nose and throat diagnoses age greater than 17.	.6045	.7525	.7291	33
74	3	Med	Other ear, nose and throat diagnoses age 0–17.	.3427	.3386	.3386	20
75	4	Surg	Major chest procedures	2.9776	2.9603	2.9860	41
76	4	Surg	Other resp system O.R. procedures with CC.	2.5663	2.3038	2.3074	39

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
77	4	Surg	Other resp system O.R. procedures without CC.	1.6734	1.0895	1.0413	34
78	4	Med	Pulmonary embolism	1.4798	1.4320	1.4372	38
79	4	Med	Respiratory infections and inflammations age greater than 17 with CC.	1.9344	1.8530	1.8144	38
80	4	Med	Respiratory infections and inflammations age greater than 17 without CC.	1.4387	1.1382	1.0404	36
81	4	Med	Respiratory infections and inflammations age 0–17.	.8652	1.0899	1.0899	35
82	4	Med	Respiratory neoplasms	1.1258	1.2016	1.2178	36
83	4	Med	Major chest trauma with CC	.8397	1.0064	.9628	35
84	4	Med	Major chest trauma without CC	.5920	.5009	.4846	28
85	4	Med	Pleural effusion with CC	1.1196	1.1437	1.1509	36
86	4	Med	Pleural effusion without CC	.9761	.7223	.6961	33
87	4	Med	Pulmonary edema and respiratory failure.	1.8076	1.4597	1.3895	35
88	4	Med	Chronic obstructive pulmonary disease	1.0768	1.0153	.9973	35
89	4	Med	Simple pneumonia and pleurisy age greater than 17 with CC.	1.1657	1.2059	1.1878	36
90	4	Med	Simple pneumonia and pleurisy age greater than 17 without CC.	.8842	.7790	.7538	31
91	4	Med	Simple pneumonia and pleurisy age 0–17.	.7914	.7465	.8141	34
92	4	Med	Interstitial lung disease with CC	1.1115	1.2182	1.2131	36
93	4	Med	Interstitial lung disease without CC	.8641	.7936	.7598	34
94	4	Med	Pneumothorax with CC	1.3044	1.3378	1.2763	36
95	4	Med	Pneumothorax without CC	.8796	.6665	.6533	34
96	4	Med	Bronchitis and asthma age greater than 17 with CC.	.8446	.9734	.9568	35
97	4	Med	Bronchitis and asthma age greater than 17 without CC.	.7091	.6810	.6561	26
98	4	Med	Bronchitis and asthma age 0–17	.7201	.8942	.6135	22
99	4	Med	Respiratory signs and symptoms with CC.	.8072	.8493	.8361	33
100	4	Med	Respiratory signs and symptoms without CC.	.6253	.5125	.5090	19
101	4	Med	Other respiratory system diagnoses with CC.	.8460	.9966	.9181	34
102	4	Med	Other respiratory system diagnoses without CC.	.6841	.5593	.5400	32
103	5	Surg	Heart transplant	.0000	13.2352	12.9086	54
104	5	Surg	Cardiac value procedure with pump and with cardiac cath.	7.3151	7.8432	8.0641	47
105	5	Surg	Cardiac value procedure with pump and without cardiac cath.	6.3388	5.9965	6.0750	42
106	5	Surg	Coronary bypass with cardiac cath	5.3324	5.6558	5.4227	43
107	5	Surg	Coronary bypass without cardiac cath	4.6608	4.2260	4.7899	40
108	5	Surg	Other cardiothoracic or vascular procedures, with pump.	4.7803	5.7332	5.9649	42
109	5	Surg	Other cardiothoracic procedures without pump.	4.3579	3.7746	0.0000	0
110	5	Surg	Major reconstructive vascular proc without pump with CC.	3.3118	3.5967	4.2644	39
111	5	Surg	Major reconstructive vascular proc without pump without CC.	2.4549	2.0351	2.4493	37

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors 1987	Relative weighting factors 1990	Relative weighting factors 1991	1991 outlier threshold
112	5	Surg	Vascular procedures except major reconstruction without pump.	2.2055	1.9106	1.9910	34
113	5	Surg	Amputation for circ system disorders except upper limb and toe.	2.5345	2.4616	2.6279	44
114	5	Surg	Upper limb and toe amputation for circ system disorders.	1.8918	1.6119	1.5827	38
115	5	Surg	Perm cardiac pacemaker implant with ami, heart failure or shock.	4.1727	3.8541	3.7705	41
116	5	Surg	Perm cardiac pacemarker implant without ami heart failure or shock.	2.9868	2.5793	2.5190	35
117	5	Surg	Cardiac pacemaker replace and revis except pulse gen replacement.	1.2989	1.8867	1.3520	33
118	5	Surg	Cardiac pacemaker pulse generator replacement.	1.9224	2.0267	1.7375	32
119	5	Surg	Vein ligation and stripping	.9164	.8269	.8169	32
120	5	Surg	Other circulatory system O.R. procedures.	2.2577	2.7059	2.5143	39
121	5	Med	Circulatory disorders with ami and C.V. comp, disch alive.	1.7687	1.6228	1.5772	37
122	5	Med	Circulatory disorders without ami without C.V. comp, disch alive.	1.3267	1.1233	1.1152	35
123	5	Med	Circulatory disorders without ami, expired.	1.3522	1.3934	1.3704	32
124	5	Med	Circulatory disorders except ami, with card cath and complex diag.	1.2551	1.1876	1.1816	33
125	5	Med	Circulatory disorders except ami, with card cath without complex diag.	.7265	.6874	.7015	21
126	5	Med	Acute and subacute endocarditis	2.9836	2.9894	2.9543	46
127	5	Med	Heart failure and shock	1.0098	1.0169	1.0040	35
128	5	Med	Deep vein thromophlebitis	.8456	.8129	.8061	34
129	5	Med	Cardiac arrest, unexplained	1.7199	1.3986	1.3242	32
130	5	Med	Peripheral vascular disorders with CC	.8251	.8921	.8969	35
131	5	Med	Peripheral vascular disorders without CC.	.6705	.5814	.5841	33
132	5	Med	Atherosclerosis with CC	.8037	.7565	.7252	33
133	5	Med	Atherosclerosis without CC	.7049	.5420	.5205	26
134	5	Med	Hypertension	.6363	.5964	.5992	33
135	5	Med	Cardiac congenital and valvular disorders age greater than 17 with CC.	.8937	.9018	.8623	34
136	5	Med	Cardiac congenital and valvular disorders age greater than 17 without CC.	.7525	.5488	.5507	26
137	5	Med	Cardiac congenital and valvular disorders age 0–17.	.6315	.6239	.6239	32
138	5	Med	Cardiac arrhythmia and conduction disorders with CC.	.8136	.8707	.8331	34
139	5	Med	Cardiac arrhythmia and conduction disorders without CC.	.6514	.5715	.5325	24
140	5	Med	Angina pectoris	.6894	.6387	.6296	25
141	5	Med	Syncope and collapse with CC	.6187	.6920	.6899	33
142	5	Med	Syncope and collapse without CC	.5335	.5149	.5012	22
143	5	Med	Chest pain	.5893	.5226	.5140	18
144	5	Med	Other circulatory system diagnoses with CC.	1.1160	1.1035	1.0849	34
145	5	Med	Other circulatory system diagnoses without CC.	.8475	.6236	.5933	29
146	6	Surg	Rectal resection with CC	3.0751	2.7386	2.5864	42

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
147	6	Surg	Rectal resection without CC	2.2735	1.7349	1.6406	36
148	6	Surg	Major small and large bowel procedures with CC.	2.9401	3.2705	3.1996	43
149	6	Surg	Major small and large bowel procedures without CC.	2.1069	1.6636	1.6044	31
150	6	Surg	Peritoneal adhesiolysis with CC	2.3426	2.6617	2.5312	41
151	6	Surg	Peritoneal adhesiolysis without CC	1.5900	1.3478	1.2777	36
152	6	Surg	Minor small and large bowel procedures with CC.	1.4059	1.4678	1.4769	37
153	6	Surg	Minor small and large bowel procedures without CC.	1.0992	1.0149	1.0170	33
154	6	Surg	Stomach, esophageal and duodenal procedures age greater than 17 with CC.	2.6876	3.8172	3.6320	41
155	6	Surg	Stomach, esophageal and duodenal procedures age greater than 17 without CC.	1.7902	1.6050	1.4768	36
156	6	Surg	Stomach, esophageal and duodenal procedures age 0–17.	.8382	.8281	.8281	35
157	6	Surg	Anal and stomal procedures with CC	.7302	.9571	.9248	34
158	6	Surg	Anal and stomal procedures without CC.	.5511	.5136	.4877	19
159	6	Surg	Hernia procedures except inguinal and femoral age greater than 17 with CC.	.9997	1.1057	1.0797	34
160	6	Surg	Hernia procedures except inguinal and femoral age greater than 17 without CC.	.7457	.6314	.6166	22
161	6	Surg	Inguinal and femoral hernia procedures age greater than 17 with CC.	.6536	.7337	.7238	32
162	6	Surg	Inguinal and femoral hernia procedures age greater than 17 without CC.	.5261	.4485	.4428	12
163	6	Surg	Hernia procedures age 0–17	.9647	.7729	.6397	32
164	6	Surg	Appendectomy with complicated principal diag with CC.	2.0646	2.3737	2.2699	39
165	6	Surg	Appendectomy with complicated principal diag without CC.	1.4375	1.3377	1.2944	25
166	6	Surg	Appendectomy without complicated principal diag with CC.	1.3604	1.3991	1.3818	36
167	6	Surg	Appendectomy without complicated principal diag without CC.	.8872	.7922	.7745	16
168	6	Surg	Mouth procedures with CC	.9182	1.0050	.9806	33
169	6	Surg	Mouth procedures without CC	.6580	.5463	.5558	18
170	6	Surg	Other digestive system O.R. procedures with CC.	2.7611	2.8091	2.7171	40
171	6	Surg	Other digestive system O.R. procedures without CC.	2.3295	1.2563	1.1583	35
172	6	Med	Digestive malignancy with CC	1.0748	1.2216	1.2445	36
173	6	Med	Digestive malignancy without CC	.9602	.6657	.6358	33
174	6	Med	G.I. hemorrhage with CC	.9073	.9620	.9537	34
175	6	Med	G.I. hemorrhage without CC	.7067	.5983	.5756	24
176	6	Med	Complicated peptic ulcer	.9316	.9831	.9830	35
177	6	Med	Uncomplicated peptic ulcer with CC	.6615	.7637	.7803	33
178	6	Med	Uncomplicated peptic ulcer without CC	.5554	.5650	.5564	22
179	6	Med	Inflammatory bowel disease	.9875	1.0648	1.0895	36
180	6	Med	G.I. obstruction with CC	.7583	.9134	.9165	35

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
181	6	Med	G.I. obstruction without CC	.5827	.5229	.5130	27
182	6	Med	Esophagitis, gastroent and misc digest disorders age greater than 17 with CC.	.6032	.7414	.7497	34
183	6	Med	Esophagitis, gastroent and misc digest disorders age greater than 17 without CC.	.5104	.5215	.5200	25
184	6	Med	Esophagitis, gastroent and misc digest disorders age 0–17.	.4828	.5408	.6801	32
185	6	Med	Dental and oral dis except extractions and restorations, age greater than 17.	.7147	.7627	.7548	33
186	6	Med	Dental and oral dis except extractions and restorations, age 0–17.	.4112	.4062	.4062	23
187	6	Med	Dental extractions and restorations	.4209	.4856	.4814	22
188	6	Med	Other digestive system diagnoses age greater than 17 with CC.	.7171	.9730	.9632	34
189	6	Med	Other digestive system diagnoses age greater than 17 without CC.	.5260	.4767	.4802	32
190	6	Med	Other digestive system diagnoses age 0–17.	.9178	.7671	.6312	28
191	7	Surg	Major pancreas, liver and shunt procedures.	4.4603	5.0674	4.6941	45
192	7	Surg	Minor pancreas, liver and shunt procedures.	4.0437	2.1816	1.9662	38
193	7	Surg	Biliary tract proc except tot cholecystectomy with CC.	2.8115	3.0026	3.0102	43
194	7	Surg	Biliary tract proc except tot cholecystectomy without CC.	2.1204	1.7802	1.7387	39
195	7	Surg	Total cholecystectomy with c.d.e. with CC.	2.2724	2.2810	2.2175	40
196	7	Surg	Total cholecystectomy with c.d.e. without CC.	1.5974	1.5106	1.4183	30
197	7	Surg	Total cholecystectomy without c.d.e. with CC.	1.7055	1.7378	1.7336	38
198	7	Surg	Total cholecystectomy without c.d.e. without CC.	1.1399	.9865	.9445	20
199	7	Surg	Hepatobiliary diagnostic procedure for malignancy.	2.3379	2.2585	2.3168	41
200	7	Surg	Hepatobiliary diagnostic procedure for non-malignancy.	2.6281	2.7160	2.8940	39
201	7	Surg	Other hepatobiliary or pancreas o.r. procedures.	2.7125	2.4093	2.4210	38
202	7	Med	Cirrhosis and alcoholic hepatitis	1.1665	1.1953	1.2019	36
203	7	Med	Malignancy of hepatobiliary system or pancreas.	1.0338	1.1174	1.1301	36
204	7	Med	Disorders of pancreas except malignancy.	.9698	1.0387	1.0617	35
205	7	Med	Disorders of liver except malig, cirr, alc hepa with CC.	1.0718	1.2068	1.1985	36
206	7	Med	Disorders of liver except malig, cirr, alc hepa without CC.	.7735	.6124	.6210	33
207	7	Med	Disorders of the biliary tract with CC	.7775	.9566	.9569	35
208	7	Med	Disorders of the biliary tract without CC.	.8793	.5658	.5599	27
209	8	Surg	Major joint and limb reattachment procedures.	2.3925	2.3437	2.3689	38

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
210	8	Surg	Hip and femur procedures except major joint age greater than 17 with CC.	2.0317	2.0536	1.9939	41
211	8	Surg	Hip and fermur procedures except major joint age greater than 17 without CC.	1.7866	1.4716	1.4302	38
212	8	Surg	Hip and femur procedures except major joint age 0–17.	1.6608	1.4023	.9981	16
213	8	Surg	Amputation for musculoskeletal system and conn tissue disorders.	1.9750	1.7701	1.7562	39
214	8	Surg	Back and neck procedures with CC	1.8749	1.9997	1.9298	39
215	8	Surg	Back and neck procedures without CC	1.4275	1.2155	1.1550	35
216	8	Surg	Biopsies of musculoskeletal system and connective tissue.	1.5565	1.7825	1.8502	38
217	8	Surg	Wnd debrid and skn grft exept hand, for muscskelet and tiss dis.	2.3097	3.0640	3.1173	43
218	8	Surg	Lower extrem and humer proc except hip, foot, femur age greater than 17 with CC.	1.3797	1.5359	1.4748	37
219	8	Surg	Lower extrem and humer proc except hip, foot, femur age greater than 17 without CC.	1.0436	.9363	.9194	31
220	8	Surg	Lower extrem and humer proc except hip, foot, femur age 0–17.	.9242	.9130	.9130	34
221	8	Surg	Knee procedures with CC	1.0141	1.5408	1.5919	36
222	8	Surg	Knee procedures without CC	.7262	.8855	.9134	33
223	8	Surg	Major shoulder or elbow proc, or other upper extremity proc, with CC.	1.2263	.8405	.8260	28
224	8	Surg	Shoulder, elbow or forearm proc, exc major joint proc, without CC.	.6894	.6248	.6224	17
225	8	Surg	Foot procedures	.6552	.7063	.7421	32
226	8	Surg	Soft tissue procedures with CC	.8783	1.4308	1.3371	35
227	8	Surg	Soft tissue procedures without CC	.6673	.6613	.6604	26
228	8	Surg	Major thumb or joint proc, or oth hand or wrist proc, with CC.	.6100	.7911	.8148	30
229	8	Surg	Hand or wrist proc, except major joint proc, without CC.	.4993	.5117	.5358	16
230	8	Surg	Local excision and removal of int fix devices of hip and femur.	1.0156	.8763	.8508	33
231	8	Surg	Local excision and removal of int fix devices except hip and femur.	.7381	.9107	.9306	33
232	8	Surg	Arthroscopy	.6723	1.1229	.9981	33
233	8	Surg	Other musculoskelet sys and conn tiss O.R. proc with CC.	1.3898	1.7280	1.8416	38
234	8	Surg	Other musculoskelet sys and conn tiss O.R. proc without CC.	.9517	.8477	.8322	33
235	8	Med	Fractures of femur	1.4136	1.1575	1.1383	37
236	8	Med	Fractures of hip and pelvis	1.0712	.8565	.8516	36
237	8	Med	Sprains, strains, and dislocations of hip, pelvis and thigh.	.6049	.5662	.5424	33
238	8	Med	Osteomyelitis	1.6471	1.5778	1.5682	39
239	8	Med	Pathological fractures and musculoskeletal and conn tiss malignancy.	.9268	.9843	1.0035	37
240	8	Med	Connective tissue disorders with CC	.9047	1.0769	1.1197	36
241	8	Med	Connective tissue disorders without CC	.7463	.6218	.5852	34
242	8	Med	Septic arthritis	1.4562	1.3229	1.2566	37
243	8	Med	Medical back problems	.6840	.6501	.6580	34

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
244	8	Med	Bone diseases and specific arthropathies with CC.	.6742	.7134	.7228	34
245	8	Med	Bone diseases and specific arthropathies without CC.	.6400	.5108	.5008	33
246	8	Med	Non-specific arthropathies	.5935	.5910	.5736	33
247	8	Med	Signs and symptoms of musculoskeletal system and conn tissue.	.5793	.5285	.5332	33
248	8	Med	Tendonitis myositis and bursitis	.5892	.6120	.6342	33
249	8	Med	Aftercare musculoskeletal system and connective tissue.	.7875	.6287	.6320	33
250	8	Med	Fx, sprn, strans and disl of forearm hand foot age greater than 17 with CC.	.5158	.6806	.6757	33
251	8	Med	Fx, sprn, strans and disl of forearm hand foot age greater than 17 without CC.	.4003	.4230	.4315	24
252	8	Med	Fx, sprn, strans and disl of uparm lowleg ex foot age 0–17.	.3496	.3454	.3454	15
253	8	Med	Fx, sprn, strans and disl of uparm lowleg ex foot age greater than 17 with CC.	.6321	.7983	.7871	35
254	8	Med	Fx, sprn, strans and of parm lowleg ex foot age greater than 17 without CC.	.4929	.4346	.4303	33
255	8	Med	Fx, sprn, strans and disl or uparm lowleg ex foot age 0–17.	.4638	.4582	.4582	32
256	8	Med	Other musculoskeletal system and connective tissue diagnoses.	.6991	.6251	.6267	33
257	9	Surg	Total mastectomy for malignancy with CC.	1.0630	.9402	.9219	26
258	9	Surg	Total mastectomy for malignancy without CC.	.9696	.7467	.7178	16
259	9	Surg	Subtotal mastectomy for malignancy with CC.	.8605	.9987	.9581	33
260	9	Surg	Subtotal mastectomy for malignancy without CC.	.6659	.5654	.5764	16
261	9	Surg	Breast proc for non-malignancy except biopsy and local excision.	.6104	.6285	.6509	15
262	9	Surg	Surg Breast biopsy and local excision for non/malignancy.	.4252	.4464	.4537	15
263	9	Surg	Skin graft and or debrid for skn ulcer or cellulitis with CC.	2.4173	2.6691	2.7750	45
264	9	Surg	Skin graft and or debrid for skn ulcer or cellulitis without CC.	2.1798	1.4197	1.3569	38
265	9	Surg	Skin graft and or debrid except for skin ulcer or cellulitis with CC.	1.3967	1.3903	1.3538	35
266	9	Surg	Skin graft and debrid except for skin ulcer or cellulitis without CC.	.7313	.6867	.6682	32
267	9	Surg	Perianal and pilonidal procedures	.6360	.5738	.6003	32
268	9	Surg	Skin, subcutaneous tissue and breast plastic procedures.	.5657	.6431	.7210	32
269	9	Surg	Other skin, subcut tiss and breast O.R. proc with CC.	1.1334	1.7287	1.7063	37
270	9	Surg	Other skin, subcut tiss and breast O.R. proc without CC.	.7622	.6744	.6709	32
271	9	Med	Skin ulcers	1.2612	1.1808	1.2568	38
272	9	Med	Major skin disorders with CC	.8524	1.0183	1.0177	36

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
273	9	Med	Major skin disorders without CC	.7971	.6811	.6664	35
274	9	Med	Malignant breast disorders with CC	1.0367	1.0610	1.1101	36
275	9	Med	Malignant breast disorders without CC	.9880	.5793	.5443	32
276	9	Med	Non-malignant breast disorders	.5677	.5602	.5710	33
277	9	Med	Cellulitis age greater than 17 with CC	.8861	.9392	.9269	36
278	9	Med	Cellulitis age greater than 17 without CC.	.7582	.6492	.6278	31
279	9	Med	Cellulitis age 0–17	.4739	.7278	.7278	24
280	9	Med	Trauma to the skin, subcut tiss and breast age greater than 17 with CC.	.5414	.6597	.6538	34
281	9	Med	Trauma to the skin subcut tiss and breast age greater than 17 without CC.	.4467	.4233	.4169	31
282	9	Med	Trauma to the skin subcut tiss and breast age 0–17.	.3424	.3383	.3383	19
283	9	Med	Minor skin disorders with CC	.6365	.7624	.7401	34
284	9	Med	Minor skin disorders without CC	.5170	.4659	.4544	33
285	10	Surg	Amputat of lower limb for endoc., nutrit, and metabol disorders.	3.2719	2.8191	2.7822	45
286	10	Surg	Adrenal and pituitary procedures	2.6727	2.5261	2.4946	39
287	10	Surg	Skin grafts and wounds debrid for endoc, nutrit, and metab disorders.	2.3776	2.2372	2.2311	43
288	10	Surg	O.R. procedures for obesity	2.1128	1.8656	1.9691	36
289	10	Surg	Parathyroid procedures	1.3304	1.0587	.9954	33
290	10	Surg	Thyroid procedures	.8561	.7805	.7394	18
291	1	Surg	Thyroglossal procedures	.6072	.4589	.4882	10
292	10	Surg	Other endocrine, nutrit and metab O.R. proc with CC.	2.3129	2.7779	2.8203	41
293	10	Surg	Other endocrine, nutrit and metab O.R. proc without CC.	1.7960	1.1289	1.0686	35
294	10	Med	Diabetes age greater than 35	.7454	.7509	.7533	35
295	10	Med	Diabetes age 0–35	.7886	.7252	.7433	33
296	10	Med	Nutritional and misc metabolic disorders age greater than 17 with CC.	.8271	.9404	.9387	35
297	10	Med	Nutritional and misc metabolic disorders age greater than 17 without CC.	.6984	.5480	.5361	32
298	10	Med	Nutritional and misc metabolic disorders age 0–17.	.7203	.6768	.5694	32
299	10	Med	Inborn effor of metabolism	.8041	.8623	.8009	34
300	10	Med	Endocrine disorders with CC	.9348	1.1086	1.1216	36
301	10	Med	Endocrine disorders without CC	.6882	.6250	.6187	33
302	11	Surg	Kidney transplant	4.6267	3.7905	3.9581	44
303	11	Surg	Kidney, ureter and major bladder procedures for neoplasm.	2.7606	2.6773	2.6416	41
304	11	Surg	Kidney, ureter and major bladder proc for non-neopl with CC.	2.0322	2.4944	2.4192	39
305	11	Surg	Kidney, ureter and major bladder proc for non-neopl without CC.	1.4893	1.2807	1.2168	34
306	11	Surg	Prostatectomy with CC	1.2593	1.4060	1.3240	36
307	11	Surg	Prostatectomy without CC	.9585	.7931	.7334	24
308	11	Surg	Minor bladder procedures with CC	1.1487	1.5067	1.4736	36
309	11	Surg	Minor bladder procedures without CC	.8644	.7882	.7815	32
310	11	Surg	Transurethral procedures with CC	.7265	.9014	.8741	33
311	11	Surg	Transurethral procedures without CC	.5564	.5211	.5178	17
312	11	Surg	Urethral procedures, age greater than 17 with CC.	.7307	.8071	.7898	33

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
313	11	Surg	Urethral procedures, age greater than 17 without CC.	.5804	.4757	.4769	20
314	11	Surg	Urethral procedures, age 0–17	.4323	.4271	.4271	26
315	11	Surg	Other kidney and urinary tract O.R. procedures.	2.7736	2.3366	2.1922	36
316	11	Med	Renal Failure	1.3210	1.2688	1.2684	35
317	11	Med	Admit for renal dialysis	.4907	.3814	.3499	21
318	11	Med	Kidney and urinary tract neoplasms with CC.	.9216	1.0637	1.0885	35
319	11	Med	Kidney and urinary tract neoplasms without CC.	.7415	.5453	.5586	32
320	11	Med	Kidney and urinary tract infections age greater than 17 with CC.	.8626	1.0261	1.0055	36
321	11	Med	Kidney and urinary tract infections age greater than 17 without CC.	.6750	.6830	.6507	29
322	11	Med	Kidney and urinary tract infections age 0–17 without CC.	.6996	.7006	.6387	29
323	11	Med	Urinary stones with CC and/or esw lithotripsy.	.5862	.7726	.7510	32
324	11	Med	Urinary stone without CC	.4096	.3964	.3932	15
325	11	Med	Kidney and urinary tract signs and symptoms age greater than 17 with CC.	.6503	.6673	.6666	33
326	11	Med	Kidney and urinary tract signs and symptoms age greater than 17 without CC.	.5156	.4276	.4286	25
327	11	Med	Kidney and urinary tract signs and symptoms age 0–17.	.5511	.5444	.5444	32
328	11	Med	Urethral stricture age greater than 17 with CC.	.5939	.6445	.6346	33
329	11	Med	Urethral stricture age greater than 17 without CC.	.4870	.4020	.4168	18
330	11	Med	Urethral stricture age 0–17	.2788	.2754	.2754	9
331	11	Med	Other kidney and urinary tract diagnoses age greater than 17 with CC.	.8329	.9501	.9493	34
332	11	Med	Other kidney and urinary tract diagnoses age greater than 17 with CC.	.6725	.5557	.5447	32
333	11	Med	Other kidney and urinary tract diagnoses age 0–17.	.7912	.8884	1.0415	34
334	12	Surg	Major male pelvic procedures with CC	1.8035	1.8224	1.7911	36
335	12	Surg	Major male pelvic procedures without CC.	1.4643	1.3462	1.3375	23
336	12	Surg	Transurethral prostatectomy with CC	.9869	.9827	.9326	28
337	12	Surg	Transurethral prostatectomy without CC.	.7788	.6603	.6329	13
338	12	Surg	Testes procedures for malignancy	.8907	.7604	.7662	32
339	12	Surg	Testes procedures for non-malignancy age greater than 17.	.5766	.5847	.5880	29
340	12	Surg	Testes procedures for non-malignancy age 0–17.	.4335	.4283	.4283	13
341	12	Surg	Penis procedures	.9970	.9851	.9850	28
342	12	Surg	Circumcision age greater than 17	.4265	.4806	.4971	24
343	12	Surg	Circumcision age 0–17	.3788	.3742	.3742	6
344	12	Surg	Other male reproductive system O.R. procedures for malignancy.	1.1214	1.0569	1.0811	34
345	12	Surg	Other male reproductive system O.R. proc except for malignancy.	.8173	.7877	.7450	33

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
346	12	Med	Malignancy, male reproductive system, with CC.	.8568	.9214	.9561	35
347	12	Med	Malignancy, male reproductive system, without CC.	.6441	.4664	.4852	32
348	12	Med	Benign prostatic hypertrophy with CC....	.6257	.6635	.6835	33
349	12	Med	Benign prostatic hypertrophy without CC.	.4853	.3828	.3847	20
350	12	Med	Inflammation of the male reproductive system.	.6270	.6716	.6657	29
351	12	Med	Sterilization, male	.3333	.3293	.3293	5
352	12	Med	Other male reproductive system diagnoses.	.5354	.5500	.5158	30
353	13	Surg	Pelvic evisceration, radical hysterectomy and radical vulvectomy.	2.3887	2.0645	2.1148	40
354	13	Surg	Uterine, adnexa proc for non-ovarian/adnexal malig with CC.	1.3563	1.4248	1.3937	35
355	13	Surg	Uterine, adnexa proc for non-ovarian/adnexal malig without CC.	1.0359	.8943	.8676	15
356	13	Surg	Female reproductive system reconstructive procedures.	.8470	.7291	.7139	18
357	13	Surg	Uterine and adnexa proc for ovarian or adnexal malig.	2.1103	2.1705	2.2286	40
358	13	Surg	Uterine and adnexa proc for non-malignancy with CC.	1.1152	1.2032	1.1515	26
359	13	Surg	Uterine and adnexa proc for non-malignancy without CC.	.9462	.8132	.7887	13
360	13	Surg	Vagina, cervix and vulva procedures......	.6338	.7760	.7643	33
361	13	Surg	Laparoscopy and incisional tubal interruption.	.6594	.6859	.8125	32
362	13	Surg	Endoscopic tubal interruption	.3510	.3490	.4921	23
363	13	Surg	D&C, conization and radio-implant for malignancy.	.6156	.6987	.6421	30
364	13	Surg	D&C, conization except for malignancy..	.3921	.4669	.4876	24
365	13	Surg	Other female reproductive system O.R. procedures.	1.9085	1.8928	1.7521	37
366	13	Med	Malignancy, female reproductive system with CC.	.8624	1.1726	1.1937	36
367	13	Med	Malignancy, female reproductive system without CC.	.5353	.4896	.4791	32
368	13	Med	Infections, female reproductive system...	.7610	.8927	.8639	35
369	13	Med	Menstrual and other female reproductive system disorders.	.5496	.5109	.5198	32
370	14	Surg	Cesarean section with CC........................	1.1063	.9848	.9284	33
371	14	Surg	Cesarean section without CC..................	.7669	.6544	.6277	11
372	14	Med	Vaginal delivery with complicating diagnoses.	.5942	.4540	.4541	19
373	14	Med	Vaginal delivery without complicating diagnoses.	.3538	.2987	.2963	8
374	14	Surg	Vaginal delivery with sterilization and or D&C.	.5754	.4981	.5204	12
375	14	Surg	Vaginal delivery with O.R. proc except steril and or D&C.	.6817	.6735	.6735	29
376	14	Med	Postpartum and post abortion diagnoses without O.R. procedure.	.4539	.3502	.3646	22
377	14	Surg	Postpartum and post abortion diagnoses with O.R. procedure.	.7698	1.5119	.6757	32
378	14	Med	Ectopic pregnancy..................................	.7357	.7232	.6686	16

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
379	14	Med	Threatened abortion	.2409	.2493	.2651	18
380	14	Med	Abortion without D&C	.3792	.2644	.2943	12
381	14	Med	Abortion with D&C, aspiration curettage or hysterotomy.	.3725	.3769	.3727	10
382	14	Med	False labor	.1136	.1186	.1101	3
383	14	Med	Other antepartum diagnoses with medical complications.	.4452	.3759	.3854	32
384	14	Med	Other antepartum diagnoses without medical complications.	.4586	.3279	.2833	27
385	15		Neonates, died or transferred to another acute care facility.	.6811	1.2084	1.2084	31
386	15		Extreme immaturity or respiratory distress syndrome, neonate.	3.6480	3.6039	3.6039	47
387	15		Prematurity with major problems	1.8267	1.8046	1.8046	42
388	15		Prematurity without major problems	1.1571	1.1431	1.1431	38
389	15		Full-term neonate with major problems	.5425	2.4098	1.4266	34
390	15		Neonate with other significant problems.	.3486	.8111	1.0001	34
391	15		Normal newborn	.2218	.2191	.2191	11
392	16	Surg	Splenectomy age greater than 17	3.2488	3.5891	3.2611	41
393	16	Surg	Splenectomy age 0–17	1.5206	1.5022	1.5022	38
394	16	Surg	Other O.R. procedures of the blood and blood forming organs.	1.0889	1.5355	1.5388	35
395	16	Med	Red blood cell disorders age greater than 17.	.7153	.7466	.7471	34
396	16	Med	Red blood cell disorders age 0–17	.2952	.3575	.3615	23
397	16	Med	Coagulation disorders	.9969	1.0955	1.1577	35
398	16	Med	Reticuldendothelial and immunity disorders with CC.	.9752	1.2279	1.1795	35
399	16	Med	Reticuldendothelial and immunity without CC.	.7247	.6906	.6576	33
400	17	Surg	Lymphoma and leukemia with major O.R. procedure.	3.1139	2.6981	2.7073	39
401	17	Surg	Lymphoma and non-acute leukemia with other O.R. proc with CC.	1.9327	2.2572	2.2071	39
402	17	Surg	Lymphoma and non-acute leukemia with other O.R. proc without CC.	1.0514	.8945	.8877	33
403	17	Med	Lymphoma and non-acute leukemia with CC.	1.3493	1.6044	1.6019	37
404	17	Med	Lymphoma and non-acute leukemia without CC.	.9101	.7753	.7474	33
405	17	Med	Acute leukemia without major O.R. procedure age 0–17.	1.0407	1.0281	1.0281	34
406	17	Surg	Myeloprolif disord or poorly diff neopl with maj O.R. proc with CC.	2.5302	2.7445	2.6994	40
407	17	Surg	Myeloprolif disord or poorly diff neopl with maj O.R. proc without CC.	1.7124	1.3042	1.2438	35
408	17	Surg	Myeloprolif disord or poorly diff neopl with other O.R. proc.	1.0500	.9592	1.0511	33
409	17	Med	Radiotherapy	.9855	1.0357	1.0213	36
410	17	Med	Chemotherapy	.4284	.4890	.5123	19
411	17	Med	History of malignancy without endoscopy.	.5907	.4543	.4320	28
412	17	Med	History of malignancy with endoscopy	.3388	.4046	.4072	21
413	17	Med	Other myeloprolif dis or poorly diff neopl diag with CC.	1.0455	1.2853	1.3073	36

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
414	17	Med	Other myeloprolif dis or poorly diff neopl diag without CC.	.8983	.7557	.7062	33
415	18	Surg	O.R. procedure for infectious and parasitic diseases.	3.3287	3.6424	3.5957	44
416	18	Med	Septecemia age greater than 17	1.6182	1.5346	1.5320	37
417	18	Med	Septecemia age 0–17	1.1530	.8929	1.0768	34
418	18	Med	Postoperative and post-traumatic infections.	1.0022	.9641	.9816	36
419	18	Med	Fever of unknown origin age greater than 17 with CC.	.9305	.9552	.9515	35
420	18	Med	Fever of unknown origin age greater than 17 without CC.	.8316	.6805	.6612	31
421	18	Med	Viral illness age greater than 17	.5672	.6337	.6517	32
422	18	Med	Viral illness and fever of unknown origin age 0–17.	.6583	.5874	.7604	33
423	18	Med	Other infectious and parasitic diseases diagnoses.	1.3205	1.5845	1.5928	37
424	19	Surg	O.R. procedure with principal diagnoses of mental illness.	2.2113	2.3418	2.3652	42
425	19	Med	Acute adjust react and disturbances of psychosocial dysfunction.	.6090	.6470	.6890	34
426	19	Med	Depressive neuroses	.8332	.6255	.6290	35
427	19	Med	Neuroses except depressive	.7018	.6133	.6428	35
428	19	Med	Disorders of personality and impulse control.	.8513	.7325	.7065	35
429	19	Med	Organic disturbances and mental retardation.	.8419	.9016	.9216	37
430	19	Med	Psychoses	1.0760	.8957	.9026	38
431	19	Med	Childhood mental disorders	.6493	.6347	.6422	34
432	19	Med	Other mental disorder diagnoses	.6968	.7329	.7405	33
433	20		Alcohol/drug abuse or dependence, left AMA.	.3906	.3974	.3829	32
434	20		ALC/drug abuse or dependence, detox or other sympt TRT with CC.	.7096	.7886	.8830	36
435	20		ALC/drug abuse or dependence, detox or other sympt TRT without CC.	.7978	.5510	.7177	36
436	20		ALC/drug dependence with rehabilitation therapy.	1.0166	.9873	.9873	37
437	20		ALC/drug dependence, combined rehab and detox therapy.	1.3273	1.2005	1.2005	33
438	20		No longer valid	.0000	.0000	.0000	0
439	21	Surg	Skin grafts for injuries	1.6505	1.6731	1.6689	36
440	21	Surg	Wound debridements for injuries	2.0421	2.4992	2.5374	40
441	21	Surg	Hand procedures for injuries	.7303	0.7381	.7189	32
442	21	Surg	Other O.R. procedures for injuries with CC.	1.8143	1.8642	1.8473	35
443	21	Surg	Other O.R. procedures for injuries without CC.	1.4841	1.1906	1.1467	33
444	21	Med	Multiple trauma age greater than 17 with CC.	.7072	.7594	.7621	34
445	21	Med	Multiple trauma age greater than 17 without CC.	.6014	.4950	.4906	32
446	21	Med	Multiple trauma age 0–17	.4796	.4738	.4738	22
447	21	Med	Allergic reactions age greater than 17	.4470	.4702	.4822	24
448	21	Med	Allergic reactions age 0–17	.3470	.3428	.3428	17
449	21	Med	Poisoning and toxic effects of drugs age greater than 17 with CC.	.6951	.7983	.7904	33

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
450	21	Med	Poisoning and toxic effects of drugs age greater than 17 without CC.	.5422	.4648	.4485	25
451	21	Med	Poisoning and toxic effects of drugs age 0–17.	.5497	.3947	.5126	33
452	21	Med	Complications of treatment with CC	.8079	.8932	.9317	34
453	21	Med	Complications of treatment without CC	.7468	.4725	.4775	32
454	21	Med	Other injury, poisoning and toxic eff diag with CC.	.8099	.9104	.9488	34
455	21	Med	Other injury, poisoning and toxic eff diag without CC.	.6002	.4226	.4282	25
456	22		Burns, transferred to another acute care facility.	1.8155	3.1114	1.5138	33
457	22		Extensive burns without O.R. procedure.	3.2280	1.8725	2.1317	32
458	22	Surg	Non-extensive burns with skin graft	3.9450	3.8130	3.7539	45
459	22	Surg	Non-extensive burns with wound debridement or other O.R. proc.	3.2658	1.9164	2.0711	40
460	22	Med	Non-extensive burns without O.R. procedure.	1.1592	1.0165	1.0607	35
461	23	Surg	O.R. proc with diagnoses or other contact with health services.	1.3548	.7762	.7771	31
462	23	Med	Rehabilitation	2.1404	1.9047	1.8435	43
463	23	Med	Signs and symptoms with CC	.7949	.7540	.7462	34
464	23	Med	Signs and symptoms without CC	.6952	.4719	.4700	31
465	23	Med	Aftercare with history of malignancy as secondary diagnosis.	.2881	.3282	.3995	21
466	23	Med	Aftercare without history of malignancy as secondary diagnosis.	.4152	.5463	.5749	32
467	23	Med	Other factors influencing health status	.7212	.4339	.4226	31
468	....		Unrelated operating room procedures	2.4516	3.3150	3.4146	42
469	....		Principal diagnosis invalid as discharge diagnosis.	.0000	.0000	.0000	0
470	....		Ungroupable	.0000	.0000	.0000	0
471	8	Surg	Bilateral or multiple major joint procs of lower extremity.	3.6991	3.9672	3.9492	43
472	22	Surg	Extensive burns with O.R. procedure	12.3234	12.7129	11.7637	50
473	17	Med	Acute leukemia without O.R. procedure age greater than 17.	2.3275	3.0963	3.2953	39
474	4		No longer valid	NA	13.4688	.0000	0
475	4	Med	Mechanical ventilation through endotrachial intubation.	NA	3.6290	3.5492	39
476	....		Prostatic O.R. procedure unrelated to principal diagnosis.	NA	2.2425	2.1816	43
477	....		Nonextensive O.R. procedure unrelated to principal diagnosis.	NA	1.4318	1.4395	35
478	05	Surg	Other Vascular Procedures w/CC			2.4189	38
479	05	Surg	Other Vascular Procedures w/o CC			1,3208	34
480	....	Surg	Liver Transplant			15.2645	52
481	....	Surg	Bone Marrow Transplant			12.4485	66
482	....	Surg	Tracheostomy w/mouth, larynx or pharynx disorder.			3.2660	43
483	....	Surg	Tracheostomy except mouth, larynx, pharynx disorder.			14.0597	69
484	24	Surg	Craniotomy for multiple significant trauma.			6.9972	43
485	24	Surg	Limb reattach, hip & femur procs for multi sign trauma.			3.2621	44

TABLE 25.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987, 1990, AND 1991 RELATIVE WEIGHTING FACTORS AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			1991 outlier threshold
				1987	1990	1991	
486	24	Surg	Other O.R. procs for multiple significant trauma.			4.9603	41
487	24	Med	Other multiple significant trauma			1.8324	37
488	25	Surg	HIV w/extensive O.R. procedure			4.1296	48
489	25	Med	HIV w/major related condition			2.0674	39
490	25	Med	HIV w/ or w/o other related condition			1.1808	35

NA—Not applicable.

Source: ProPAC and Federal Register, September 4, 1990.

APPENDIX E. MEDICARE REIMBURSEMENT TO PHYSICIANS

CURRENT PAYMENT RULES

Medicare pays for physicians' services on the basis of *reasonable charges.* A reasonable charge for a service can not exceed: (1) the physician's *actual charge* for the service; (2) the physician's *customary charge* for the service; or (3) the *prevailing charge* for the service in the locality. Medicare generally pays 80 percent of the reasonable charge after the beneficiary has met the $100 deductible. The beneficiary is responsible for the remaining 20 percent, known as coinsurance.

Customary and prevailing charge fee screens (i.e., benchmarks against which individual charges are compared) are determined by locality and updated annually. There are approximately 237 localities in the country; current localities are not homogenous in terms of size, population, or type of area (urban or rural). The increase in the prevailing charge screen is subject to a limit known as the *Medicare Economic Index (MEI).* The MEI is a limit on the cumulative changes in prevailing charges since 1973.

Originally, the MEI was set to reflect changes in operating expenses and earnings levels of physicians. However, since the Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369), Congress has established the MEI update by law at a level lower than would have occurred if HCFA had calculated the index value. Congress set the MEI at zero from July 1, 1984, through September 30, 1985, meaning that prevailing charges were frozen during this period. The MEI update scheduled to go into effect on October 1, 1985, was eliminated and the freeze extended to until May 1, 1986. At that point, only the prevailing charges of participating physicians were increased; their increase was limited to 4.15 percent.

The freeze continued for nonparticipating physicians until January 1, 1987, when Congress set an MEI of 3.2 percent for all physicians in the Omnibus Budget Reconciliation Act of 1986 (OBRA 86, P.L. 99-509). In the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, P.L. 100-203), Congress again used the MEI as a deficit reduction tool by delaying the MEI update from January 1, 1988, until April 1, 1988, and providing differential MEI updates to different types of services and physicians. From April 1, 1988, to December 31, 1988, Congress set the MEI at 3.6 percent for primary care services (defined as home, office, emergency room and nursing home visits) and 1 percent for all other services. Because OBRA 1987 was a 2-year deficit reduction measure, it also set the MEI for 1989. In addition to retaining the concept of higher updates for primary care services, OBRA 1987 specified that the prevailing charges for nonparticipating physicians would be 95.5 percent of that for participating physicians. Effective January 1, 1989, nonparticipating physicians had a prevailing charge equal to 95 percent of that for participating physicians.

TABLE 1.—MEDICARE ECONOMIC INDEX AND PERCENTAGE INCREASES OVER PRIOR PERIOD, 1973–1991

Fee screen period	Index value	Annual increase (percent)
July 1, 1973	1.000	NA
July 1, 1975 to June 30, 1976	1.179	17.90
July 1, 1976 to June 30, 1977	1.276	8.23
July 1, 1977 to June 30, 1978	1.357	6.35
July 1, 1978 to June 30, 1979	1.426	5.08
July 1, 1979 to June 30, 1980	1.533	7.50
July 1, 1980 to June 30, 1981	1.658	8.15
July 1, 1981 to June 30, 1982	1.790	7.96
July 1, 1982 to June 30, 1983	1.949	8.88
July 1, 1973 to June 30, 1984	2.063	5.85
July 1, 1984 to Apr. 30, 1986	2.063	[1] 0
May 1, 1986 to Dec. 31, 1986	2.149	[2] 4.15
Jan. 1, 1987 to Mar. 31, 1988	2.218	[3] 3.20
Primary care services:		
Apr. 1, 1988 to Dec. 31, 1988	2.298	[4] 3.60
Jan. 1, 1989 to Mar. 31, 1990	2.367	[5] 3.00
Apr. 1, 1990 to Dec. 31, 1990	2.466	[6] 4.20
Jan. 1, 1991 to Dec. 31, 1991	2.515	2.00
Other services:		
Apr. 1, 1988 to Dec. 31, 1988	2.240	[4] 1.00
Jan. 1, 1989 to Mar. 31, 1990	2.263	[5] 1.00
Apr. 1, 1990 to Dec. 31, 1990	2.308	[7] 2.00
Jan. 1, 1991 to Dec. 31, 1991	2.308	0
Anesthesiology, radiology and overvalued procedures: [8]		
Apr. 1, 1990 to Dec. 31, 1990	2.263	0
Jan. 1, 1991 to Dec. 31, 1991	2.263	0

[1] MEI was held constant during fee freeze.

[2] Percentage increase was mandated by Public Law 99–272 and applied only to participating physicians.

[3] Percentage increase was mandated by Public Law 99–509 and applied to both participating and nonparticipating physicians. Prevailing charges of nonparticipating physicians were 96 percent of the prevailing charges for participating physicians.

[4] Percentage increase was mandated by Public Law 100–203. Prevailing charges for services provided by nonparticipating physicians are 95.5 percent of the prevailing charges for participating physicians.

[5] Percentage increase was mandated by Public Law 100–203. Prevailing charges for services provided by nonparticipating physicians are 95 percent of the prevailing charges for participating physicians.

[6] Prevailing charges for services provided by nonparticipating physicians are 95 percent of the prevailing charges for participating physicians.

[7] Percentage increase was mandated by P.L. 100–239. Prevailing charges for services provided by nonparticipating physicians are 95 percent of the prevailing charges for participating physicians.

[8] Services considered overpriced are specified in table 2 in the "Joint Explanatory Statement of the Committee of Conference" submitted with the conference report to accompany P.L. 100–239.

NA—Not applicable.

In 1989, participating physicians providing primary care services received an MEI update of 3 percent, while nonparticipating physicians providing primary care services received an MEI update of 2.5 percent. Participating physicians providing services other than primary care received a 1 percent MEI update; nonparticipating physicians providing similar services received an MEI update of 0.5 percent. Beginning April 1, 1990, primary care services received a full MEI update of 4.2 percent, while anesthesiology, radiology and overvalued procedures got a zero-percent update. All other physicians' services received a 2-percent update. In 1991, primary care service's received a 2.0 percent update; no update was granted for all other services. OBRA 1990 specified that the update otherwise applicable for 1992 will be reduced by 0.4 percent.

Medicare payments for services are made directly to the physician or the patient, depending on whether the physician has accepted *assignment* for the claim. In the case of assigned claims, the physician bills the program directly and is paid an amount equal to 80 percent of the reasonable charges (less any deductible where applicable). The patient is liable for 20 percent coinsurance. The physician may not charge the beneficiary more than the applicable deductible and coinsurance amounts. In the case of nonassigned claims, Medicare payment is made to the beneficiary. The beneficiary pays the physician's bill. In addition to the deductible and coinsurance amounts, the beneficiary is liable for the difference between the physician's actual charge and Medicare's approved charge; this is known as the *balance billed* amount.

A physician may become a participating physician. A participating physician is one who voluntarily enters an agreement with the Secretary of the Department of Health and Human Services to accept assignment on all claims for the forthcoming year. The law includes a number of incentives to encourage physicians to participate. For example, the difference between the MEI-adjusted prevailing changes for participating and nonparticipating physicians is 5 percent.

From 1987 through 1990 the program specified a limit on the actual charges of nonparticipating physicians. This is referred to as the *maximum allowable actual charge or MAAC*. Nonparticipating physicians whose actual charge for a service in the preceeding year equaled or exceeded 115 percent of the 1990 prevailing charge could increase their actual charges by no more than 1 percent. Nonparticipating physicians whose actual charge for the preceding year was below 115 percent of the current year's prevailing charge could increase their actual charges over a 4-year period (1987–1990), such that, in 1990 their MAAC for the service equaled 115 percent of the prevailing charge.

OBRA 1989 enacted new limits on actual charges of nonparticipating physicians. In 1991, the limit on charges for nonparticipating physicians is the same percentage (not to exceed 25 percent) above the 1991 recognized payment amount as their 1990 MAAC was above the 1990 recognized payment amount. This is referred to as the 125 percent limit. The limit is reduced to 120 percent in 1992 and 115 percent in 1993. However, for 1991 only, the limit for evaluation and management services is 140 percent. These services include: primary care services; hospital inpatient medical services;

consultations and other visits; preventive medicine services; psychiatric services; emergency care services; and critical care services.

PHYSICIAN PAYMENT REFORM

Congress enacted a fundamental restructuring of Medicare physician reimbursement in the 1989 Omnibus Budget Reconciliation Act (OBRA 1989, P.L. 101-239). From the inception of Medicare in 1966 until the enactment of OBRA 1989, physicians had been reimbursed on the basis of reasonable charges.

The impetus for physician payment reform arose from several sources. Probably the most significant was the realization that the reasonable charge reimbursement system contributed significantly to rapidly growing expenditures in Medicare part B. Under reasonable charge reimbursement principles, Medicare spending for physicians' services increased at an average annual rate of 11.7 percent from 1965 to 1989, far outstripping the rate of medical care inflation and the rate of growth in Medicare enrollees.

Calls for reform of the reasonable charge reimbursement system also stemmed from recognition of its inherent inequities. When Medicare was implemented in 1966, reimbursement was based on physicians' historical charges, which exhibited wide variation both within and across localities. Historical variations in charges continued over time. For example, data showed that prevailing charges for a total hip replacement varied widely for such similar areas as Los Angeles, Chicago, New York, and Washington, D.C. In addition, Medicare reimbursement has been structured so that reimbursement for complicated, "high-tech" procedures has generally been more generous than payments for primary care or time intensive procedures. Recently Congress has addressed these concerns by providing for payment reductions for certain "overvalued procedures."

For all of these reasons, Congress was receptive to a different physician reimbursement structure. In addition to enacting a new payment structure in OBRA 1989, Congress also created a volume performance standard designed to moderate growth in volume of physicians' services and established new limits on actual charges. Taken together, these three elements are referred to as the three part physician payment reform package. In addition, Congress authorized increased funding for research on medical care outcomes and effectiveness of medical care.

MEDICARE FEE SCHEDULE

Under the new law, which takes effect over a 5-year period beginning in January 1992, physicians will be reimbursed on the basis of a Medicare fee schedule (MFS) that sets payments to physicians according to the time, skill and intensity of the service rendered, rather than on historical charges. The fee schedule will apply to all physicians' services including diagnostic tests and x rays furnished in connection with physicians' services. It will not apply to clinical diagnostic laboratory tests and other items and services the Secretary may choose to exclude. Payments for a service will not vary by the specialty of the physician performing the service, in accordance with the general principle that payments should be made for the service performed regardless of the specialty of the physician performing the service.

The *fee schedule* amount for a service is equal to the product of: (1) the *relative value* for the service; (2) the *conversion factor* for the year; and (3) the *geographic adjustment factor* for the service for the fee schedule area.

Relative Value Scale

The *relative value* for a procedure has three components: (1) a *physician work component,* which measures the time, skill and intensity of the service; (2) a *practice expense component,* which measures the costs that physicians incur in practicing medicine, such as office rent and the salaries of personnel; and (3) a *malpractice component,* which measures the costs of maintaining malpractice insurance for that service. The proportions that each of these three components have in the relative value for a particular service varies, depending upon a weighted average of specialty specific practice expense and malpractice data.

Conversion Factor

The *conversion factor* is a multiplier that is used to convert the relative value into a dollar payment for a service. The conversion factor for each year is the previous year's conversion factor adjusted by the *update* for the year involved. Beginning in 1991, the Secretary is required to report recommendations for an update to the conversion factor for the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. In making recommendations, the Secretary is required to consider the following:

—The increase in the Medicare Economic Index (MEI) for the year;
—The percentage change in actual physician expenditures in the preceding fiscal year;
—The percentage change in expenditures from the volume performance standard for the fiscal year;
—Changes in volume and intensity of services;
—Access to services; and
—Other factors that may contribute to changes in volume or access.

The Physician Payment Review Commission (PPRC) is required to review the Secretary's report and submit its recommendations by May 15 of each year. Congress is generally expected to specify the update for each year, but OBRA 1989 provided a minimum default update if Congress fails to enact one. The default update is equal to the Secretary's estimate of the MEI increased or decreased by the percentage difference between the increase or decrease in actual expenditures and the volume performance standard for the second previous fiscal year. OBRA 1989 also specified a floor, or minimum amount, that the default update must increase. In 1992 and 1993, the minimum update must be at least the MEI minus 2 percent. In 1994 and 1995, the update must be at least the MEI minus 2.5 percent. In subsequent years, the minimum update is the MEI minus 3 percent.

Geographic Adjustment Factor

The Secretary is required to establish a geographic adjustment factor for all physicians' services for each fee schedule area, which are now defined as current Medicare localities. The geographic adjustment factor is equal to the sum of the following:

Geographic Cost of Practice Adjustment Factor.—This is the product of:

—The proportion of total relative value units for the service reflecting the practice expense component, and

—The geographic cost-of-practice index for the area for the service. This index reflects the relative cost of the mix of goods and services comprising practice expenses in the different fee schedule areas compared to the national average. The Secretary may establish class-specific indices if the application of a single index would be substantially inequitable.

Geographic Malpractice Adjustment Factor.—This is the product of:

—The proportion of total relative value units for the service reflecting the malpractice component, and

—The geographic malpractice index for the area. This index reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average.

Geographic Physician Work Adjustment Factor.—This is the product of:

—The proportion of total relative value units for the service reflecting the work component, and

—The geographic physician work index value for the area. This index reflects one-fourth of the difference between the relative value of physicians' work effort in each of the different fee schedule areas compared to the national average.

Phase-In of the Medicare Fee Schedule

The Medicare fee schedule is slated to be phased in over a 5-year period beginning in 1992. For services whose payment levels in 1992 would otherwise be less than 15 percent over or under the fee schedule amount, payment will be made solely on the basis of the fee schedule, beginning in 1992. The payment levels in 1992 are defined as the weighted average prevailing charge in the locality in 1991, adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations.

For services whose 1992 payment amounts are not within 15 percent of the amount that would be paid under the fee schedule, the 1992 payment is increased or decreased by 15 percent of the fee schedule amount, whichever is appropriate. In 1993, payment is equal to 75 percent of the previous year's payment amount adjusted by the update factor and 25 percent of the fee schedule payment amount. In 1994, the previous year's reasonable charge payment amount accounts for 67 percent of the payment, with the remaining 33 percent based on the fee schedule payment. In 1995, the split is 50–50; in 1996, all payments are to be based on the fee schedule amount.

VOLUME PERFORMANCE STANDARDS

The second part of the Medicare physician payment reform package consists of volume performance standards, which are designed to create incentives to moderate the rate of growth in expenditures for physicians' services. Volume performance standards are used to advise the Congress in setting the appropriate update to the conversion factor each year.

Congress specified the formula for the volume performance standard for 1990 in OBRA 1989 and is generally expected to set it for succeeding years, but the law also provides for a default volume performance standard in the absence of congressional action.

The default formula provides an estimate of how much physician expenditures would increase in a given year, which is then adjusted downward by a small, but increasing, negative performance standard to incorporate congressional desire to check the rate of growth in physician expenditures. The volume performance standard for 1991 has been set at 7.3 percent for all physican services, 3.3 percent for surgical services and 8.6 percent for nonsurgical services.

The components used to derive the 1991 and default volume performance standards include all of the elements that typically contribute to increases in physicians' expenditures, offset by a negative performance standard factor. The performance standard factor, which is −0.5 percent in 1990, −1 percent in 1991, −1.5 percent in 1992 and −2.0 percent in subsequent years, is the percentage reduction in physician expenditures that Congress wants to achieve in the rate of growth that would have occurred absent the performance standard factor.

The components of the default volume performance standard are the product of the following:

- —The Secretary's estimate of the weighted average percentage increase in fees for physicians' services in the calendar years included in the current fiscal year;
- —The Secretary's estimate of the percentage change in part B enrollees;
- —The Secretary's estimate of the average annual percentage growth in volume and intensity of services for the 5 fiscal year period ending with the preceding fiscal year;
- —The Secretary's estimate of the percentage change in physician expenditures in the fiscal year (not taken into account above) which will result from changes in laws or regulations; and
- —The performance standard factor.

OBRA 1989 permits the Secretary to establish separate group specific performance standard factors. However, these standards could not be introduced before the Secretary's report on this issue, due July 1, 1990, or before October 1, 1991. After that, the Secretary is required to implement a plan under which qualified physicians' groups could annually elect their own specific performance standard rates. The Secretary is required to develop criteria to determine which physician groups are eligible to elect separate performance standard rates and the method by which these standards would be adopted. The Secretary must report on this issue by April 15, 1991, and PPRC is required to comment on the Secretary's plans a month later. Before implementing a plan, the Secretary must consult with physician groups and publish a notice in the Federal Register. In addition, specific congressional approval is required before separate performance group standards can be adopted.

LIMITS ON BENEFICIARY LIABILITY

The new physician payment structure retains key operating concepts of the current reimbursement system: *assignment* and the *participating physician program*. These concepts remain in the new physician payment structure because they protect beneficiaries from unanticipated out of pocket costs.

The new limits on the actual charges of nonparticipating physicians, which took effect in 1991, are calculated differently from existing limits. The new limiting charges are set at a maximum percentage above the recognized payment amount (the prevailing charge in 1991 or the Medicare fee schedule amount in subsequent years) for nonparticipating physicians. Recognized payment amounts for nonparticipating physicians are 95 percent of such amounts for participating physicians. The limiting charges are therefore a percentage of this reduced amount.

In 1991, a physician's limiting charge is the same percentage (not to exceed 25 percent) above the 1991 recognized payment amount as their 1990 MAAC was above the 1990 recognized payment amount. This is referred to as the 125-percent limit. In 1991 only, the limit for evaluation and management services, is 140 percent. For 1992, a physician's limiting charge is the same percentage (not to exceed 20 percent) above the 1992 payment amount as their 1991 limiting charge was above the 1991 recognized payment amount. This is referred to as the 120-percent limit. For 1993 and subsequent years, the limiting charge for all physicians is 115 percent of the recognized payment amount for nonparticipating physicians for the year.

MEDICAL CARE OUTCOMES AND EFFECTIVENESS RESEARCH

In the fourth part of the physician payment reform package, Congress created a new agency, the Agency for Health Care Policy and Research, which replaces the existing National Center for Health Services Research in the Public Health Service. The mission of the new agency is to enhance the quality, appropriateness and effectiveness of health care services and access to such services. These goals are to be accomplished by establishing a broad base of scientific research and promoting improvements in the clinical practice of medicine and the organization, financing and delivery of health care services.

Specifically, the agency is directed to conduct and support research, demonstration projects, evaluations, training, guideline development and the dissemination of information on health care services and delivery systems, including activities on: (1) the effectiveness, efficiency, and quality of health care services; (2) the outcomes of health care services and procedures; (3) clinical practice, including primary care and practice-oriented research; (4) health care technologies, facilities and equipment; (5) health care costs, productivity and market forces; (6) health promotion and disease prevention; (7) health statistics and epidemiology; and (8) medical liability.

EFFECTS OF PHYSICIAN PAYMENT REFORM

The precise effects of the fee schedule on physician payments are not known yet. The Health Care Financing Administration (HCFA) will issue proposed rules on implementing the fee schedule in April 1991. These proposed rules, which will establish the relative values to be used in the fee schedule, will provide a clearer picture of how the fee schedule will affect actual physician payments. Generally, the fee schedule is expected to increase payments for primary care services and decrease payments for major surgical and diagnostic procedures.

The fee schedule is also expected to affect physician specialties differently. Payments to physicians providing primarily evaluation and management services, such as family practitioners and internal medicine specialists, will increase, while payments to physicians providing primarily surgical care, like thoracic surgeons, ophthalmologists, and general surgeons, will decrease.

The fee schedule is also projected to redistribute physician payments by geographic area. Adjustments for geographic differences in the costs of practicing medicine may alter the simulation results shown in table 2. These simulations, conducted by the Physician Payment Review Commission in 1990, show substantial increases in payments to most rural physicians. Payments to physicians practicing in the largest urban areas (metropolitan areas of at least 1 million population) will decrease slightly. Within each type of geographic area, physicians in medical specialties will receive higher payments and surgical specialists will receive lower payments.

In its 1991 Annual Report to Congress, the Physician Payment Review Commission commented on the status of the fee schedule's implementation. The Commission reported that many of the payment reductions in OBRA 1989 and OBRA 1990 sped the rate of change toward relative value payments under the fee schedule. Commission simulations suggested that payment reductions in OBRA 1989 and OBRA 1990 have resulted in 20 percent of the transition being accomplished prior to the January 1992 implementation of the fee schedule. The Commission also estimated that 52 percent of the total change in payment rates and 70 percent of the increased payments for evaluation and management services will occur prior to or during 1992. The balance of payment changes is slated to be implemented in four equal increments between 1993 and 1996.

TABLE 2.—CHANGE IN MEDICARE PAYMENTS BY GEOGRAPHIC AREA

[Simulated for 1988]

Area	Specialty group	Percent
Metropolitan > 3 million	Medical	10
	Surgical	−15
	All physicians	−4
Metropolitan between 1 and 3 million	Medical	14
	Surgical	−14
	All physicians	−5
Metropolitan < 1 million	Medical	22
	Surgical	−9
	All physicians	1
Rural county > 25,000	Medical	28
	Surgical	−5
	All physicians	12
Rural county < 25,000	Medical	34
	Surgical	−8
	All physicians	13

Note.—Change from average 1988 charges under reasonable charge payment to a fee schedule based on resource costs.

Source: PPRC simulations, 1986 BMADIII aged to 1988.

OTHER PROVISIONS REGARDING PHYSICIAN PAYMENTS

Updates in the Medicare Economic Index

In the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989, P.L. 101-239) Congress delayed the MEI update from January 1, 1990 to April 1, 1990. In addition to the delay, physician payments were subject to a 2.09 percent sequester, pursuant to the provisions of the Gramm-Rudman-Hollings Deficit Reduction Act, until March 31, 1990, and to an estimated 1.42 percent sequester from April 1, 1990 to December 31, 1990.

Congress set the MEI update for 1990 at 0 percent for radiology services, anesthesia services and overvalued procedures, 2 percent for services other than primary care services and the full MEI update for primary care services. The MEI for primary care services was 4.2 percent.

OBRA 1990 reduced payment for all items and services furnished under part B, including physicians' services, by 2 percent from November 1, 1990, through December 31, 1990.

OBRA 1990 also set the MEI for 1991 at zero percent for all services except primary care services, which means that the prevailing and customary charges are frozen at 1990 levels. Primary care services received a 2 percent update for 1991. In addition, OBRA 1990 also specified that the MEI update for 1992 would be reduced by four-tenths of a percent below what it otherwise would be.

Reductions in Payments for Identified Overvalued Procedures

In OBRA 1987, Congress imposed reductions in prevailing charges for procedures that were identified as being overvalued or overpriced by the Physician Payment Review Commission. Most of the identified procedures were diagnostic or surgical procedures, such as coronary artery bypass surgery and upper gastrointenstinal endoscopy. For the 9-month period beginning April 1, 1988, prevailing charges for overvalued procedures were reduced by 2 percent and then were further reduced by a sliding scale amount between 0 and 15 percent that was determined by comparing the local prevailing charge with the weighted national average prevailing charge.

Prevailing charges exceeding 150 percent of the national average were reduced by 15 percent, while prevailing charges less than 85 percent of the national average were not reduced by the sliding scale. Prevailing charges between 85 percent and 150 percent of the national average were reduced by three-thirteenths of 1 percent for each percent of the prevailing charge exceeding 85 percent of the national average. In 1989, the maximum paid to physicians was the sum of their reduced prevailing charges plus one-half the difference between physicians' actual charges and the allowed prevailing charge. In addition, judicial or administrative review of the Secretary's determinations of prevailing charge floors was prohibited.

Special limits were also imposed on actual charges for overvalued procedures performed by nonparticipating physicians. In 1988, the limit was set halfway between 125 percent of the reduced prevailing charge and the previous year's limit on actual charges. In 1989, the limit was 125 percent of the reduced prevailing charge.

In OBRA 1989, Congress again set limits on prevailing charges of overvalued procedures, but the list of procedures the reductions apply to was longer than the list subjected to reductions in OBRA 1987, and the reductions were calculated somewhat differently. For the 9-month period beginning April 1, 1990, the prevailing charges for procedures that PPRC identified as being at least 10 percent overvalued were reduced by up to 15 percent. Procedures were identified as being overvalued based on a comparison of what payments would be under a resource-based relative value scale and national average prevailing charges.

The reductions were equal to one-third of the difference between the 1989 prevailing charge and the locally adjusted reduced prevailing amount up to a maximum of 15 percent. The locally adjusted reduced prevailing amount is defined as the reduced national weighted average prevailing charge multiplied by an adjustment factor. Reduced national weighted average prevailing charges are defined as 1989 national weighted average prevailing charges reduced by a procedure specific percentage identified in an appendix to the law. The adjustment factor for a locality is defined as the sum of: (1) a practice expense ratio (which is specific to each service and identified in an appendix to the law) multiplied by the geographic practice cost index value; and (2) 1 minus the practice expense ratio. (The Secretary is directed to determine the national weighted average prevailing charges using the best data available.)

In addition to the reductions for overvalued procedures, special limits were applied to the actual charges of nonparticipating physicians providing overvalued procedures. In 1990, the limit on actual charges was equal to the halfway point between 125 percent of reduced prevailing charges plus one-half of the difference between their reduced prevailing charges and their actual charges in 1990. In 1991, the special limit is 125 percent of the reduced prevailing charge.

OBRA 1990 made two types of reductions in payments for overvalued procedures. The first made further reductions in payments for the same list of procedures considered overvalued by OBRA 1989. It further reduced the prevailing charges for these procedures by an additional one third of the difference between the 1990 prevailing charge and a local prevailing charge, which is adjusted for local variations in practice costs in the same manner as in OBRA 1989. As in OBRA 1989, the maximum reduction is 15 percent.

The second type reduced the 1991 prevailing charge by 6.5 percent for procedures not categorized as overvalued in OBRA 1989, but subsequently identified as overvalued by the Physician Payment Review Commission. These are referred to as unsurveyed surgical and technical procedures. All physician procedures not specifically excluded are subject to the second type of reduction. Excluded procedures include the following: (1) overvalued procedures subject to reductions in OBRA 1989; (2) radiology, anesthesiology and pathology services; (3) evalution and management services; (4) the technical component of diagnostic tests subject to a national median cap; and (5) specified services estimated to be overvalued by less than 6.5 percent.

Customary Charges of New Physicians

In OBRA 1987, Congress established lower customary charges for new physicians based on the fact that adequate actual charge data were not available to set customary charge levels because they had been in practice for an insufficient period of time. The limit on the customary charges of new physicians was set at no more than 80 percent of the prevailing charge for the service. OBRA 1989 extended this policy by reducing customary charges for new physicians in their second year of practice to no more than 85 percent of the prevailing charge for the service.

OBRA 1990 expanded the concept of reducing new physicians' charges by limiting the customary charges of physicians in their third year of practice to 90 percent of the prevailing charge, and 95 percent in the fourth year of practice. It also extended the limits on charges by applying them to health care practitioners, who include physicians' assistants; certified nurse-widwives; qualified psychologists; nurse practitioners; clinical social workers; physical and occupational therapists; certified registered nurse-anesthetists; or other practitioners specified by the Secretary.

Limitations on Charges for Services Performed by More Than One Specialty

OBRA 1989 limited the prevailing charge for radiology, surgery and diagnostic physicians' services to the prevailing charge or fee schedule amount applicable to the specialty that performs the service most frequently nationwide. The charges of nonparticipating physicians performing these procedures are also subject to special limits on actual charges. In 1990, nonparticipating physicians could not charge more than 125 percent of the reduced prevailing charge plus one-half of the difference between the previous year's maximum allowable actual charge (MAAC) and the reduced prevailing charge. In 1991, the limit on actual charges is 125 percent of the reduced prevailing charge.

PAYMENTS FOR ANESTHESIOLOGY SERVICES

Reasonable charges for anesthesiology services are currently based on what are known as relative value units (RVUs). RVUs measure the complexity and duration of effort required to provide anesthesiology services to a patient. Physicians giving anesthesiology services to patients having more complex surgery or whose surgery takes a longer period of time are allowed more RVUs than simple cases with short surgical times. The RVUs are then converted into a reasonable charge value by multiplying the RVUs times a conversion factor.

The number of RVUs recognized for payment purposes generally is the sum of two elements. First, each surgical procedure is assigned a number of *base units*; more complex procedures have a higher number of base units. Second, anesthesiologists bill for a varying number of *time units* based on the duration of the procedure. For each anesthesiology service, the reasonable charge is the smallest of (1) the actual charge, (2) the allowed relative value units times the physician's customary conversion factor, and (3) the allowed relative value units times the prevailing conversion factor in the locality. The customary and prevailing conversion factors are determined in the same fashion as for other physician services. The carrier estimates a customary conversion factor based on each physician's historical charges; prevailing conversion factors are the 75th percentile of the ranked customary conversion factors, subject to the MEI limit.

The number of base units recognized for an anesthesiologist supervising procedures concurrently is reduced. The amount of the reduction is 10 percent for physicians supervising two procedures concurrently; 25 percent for supervising three procedures concurrently; and 40 percent for four concurrent procedures.

Recent Legislative Changes

OBRA 1987 initially directed the Secretary to issue a uniform relative value guide for services performed on or after January 1, 1989 to standardize use of RVUs by carriers. In OBRA 1989, Congress specified that this guide should result in budget-neutral expenditures. OBRA 89 also specified that the time units used in calculating the RVUs are to be based on actual time, instead of being rounded up to 15 minute units used previously.

A final rule implementing the relative value guide was published in the Federal Register on August 2, 1990. The rule indicated that Medicare would use the 1988 American Society of Anesthesiologists relative value guide with a few modifications. Modifier units, which had been used by about 35 percent of carriers, are not recognized under the new rule. In addition, only base units identified in the Physicians' Current Procedure Terminology, Fourth Edition (CPT-4) anesthesia codes are approved; base units associated with surgery or medical service codes are not approved.

OBRA 1990 reduced anethesia conversion factors by up to 15 percent, but also established a floor for local conversion factors. The floor is equal to 60 percent of the national average weighted conversion factors. The reduction is equal to the lesser of a 15 percent reduction in the local prevailing charge conversion factors or the amount, if any, by which the local prevailing charge conversion factors exceed the 1990 weighted national average prevailing charge conversion factor, which is both reduced by 7 percent and adjusted for physician work and geographic variations in practice costs. Seventy percent of the prevailing charge conversion factor is attributed to physician work.

OBRA 1990 also continued the reductions in payments to anesthesiologists supervising multiple concurrent procedures performed by certified registered nurse anesthetists.

CERTIFIED REGISTERED NURSE ANESTHETISTS

Physicians may bill for the supervision of anesthesia care provided by certified registered nurse anesthetists (CRNAs), and may supervise up to four procedures concurrently performed by CRNAs. If the physician employs the CRNA (and therefore pays the CRNA's salary), the same payment is made as if the physician had performed the service. If the CRNA is not employed by the supervising physician, either because the CRNA practices independently or is an employee of the hospital, the supervising physician may bill for only one time unit per 30 minutes. That is, the payment to the supervising physician is reduced because the physician is not paying for the CRNA's services.

The Omnibus Budget Reconciliation Act of 1986 (OBRA) permitted CRNAs to bill Medicare directly for their services for a 2-year period beginning January 1, 1989. The reasonable charge for CRNA services is the lesser of the actual charge and a fee schedule amount. The Secretary was required to develop the fee schedule and could design the schedule to use similar base and time units as currently in use for physician anesthesiology services. CRNAs billing Medicare directly can submit claims for their services only on an assigned basis.

Aggregate reimbursement to CRNAs under the fee schedule could not exceed total payments that would have been made in 1989 and 1990 under the previous reimbursement system. Regulations implementing the fee schedule were proposed in January 1989 and implemented through carrier instructions. Because reimbursement under the fee schedule had to be budget neutral, the conversion factors used in the fee schedule were considerably lower than anticipated in comparison to hospital costs.

Recent Legislative Changes

OBRA 1989 made one change in reimbursement policy regarding CRNAs. Under previous law, certain rural hospitals that met specified criteria could pay CRNAs on a cost-basis instead through the prospective payment system if they performed less than 250 surgical procedures a year. Under OBRA 1989, the annual number of surgical procedures that could be performed while still qualifying for the cost-based payment was raised from 250 to 500.

OBRA 1990 provided for yearly increases in the conversion factors used in the CRNA fee schedule between 1991 and 1996. In 1996, the conversion factor for nonmedically directed CRNAs (those who practice independently) will equal the expected conversion factor for anesthesiologists. Payments for medically directed CRNAs (those supervised by an anesthesiologist) will equal 70 percent of the expected conversion factor for anesthesiologists. OBRA 1990 also directed that the CRNA fee schedule consist of base and time units, with 70 percent of the conversion factor attributable to work and 30 percent attributable to overhead. In addition, it continued the cost-based passthrough for CRNAs working in rural hospitals that perform less than 500 surgeries a year.

Payments for Radiology Services

OBRA 1987 established a fee schedule for radiology services provided by board certified radiologists for whom radiology services constitute half of their Medicare billings. The fee schedule is based on a relative value scale, which assigns a relative value to each procedure and is converted into a dollar amount by a conversion factor. The fee schedule was to be implemented on January 1, 1989, but was not implemented until April 1, 1989. Reimbursement for 1989 was limited to 97 percent of the payment amount determined by the conversion factors. Updates for years after 1989 were scheduled to be based on the previous year's fee schedule updated by the MEI.

Limits were placed on the amounts that nonparticipating physicians subject to the radiology fee schedule were permitted to charge. For 1989, the limit was 125 percent of the fee schedule amount. In 1990, the limit was 120 percent. After 1990, the limit is 115 percent.

Prior to the implementation of the radiology fee schedule, some interventional radiologists and cardiologists performing procedures using radiology, such as angioplasty, submitted two bills, one for the surgical component of their services and one for supervision and interpretation of the procedure. HCFA issued carrier instructions that permitted this "split-billing" to continue in 1989 while it worked on methods to incorporate both parts of the service into the radiology fee schedule.

Recent Legislative Changes

OBRA 1989 made several changes in payments for radiology services under the fee schedule, most of which resulted in reductions in payments. The MEI update to the fee schedule was eliminated for the first 3 months of 1990. For the balance of the year, payment under the fee schedule was based on 96 percent of the amount allowed under the conversion factors. The effect of this provision was a 4-percent reduction in 1990 payments compared to 1989 payments.

Several types of services or providers of specialized types of radiology services were granted partial exemptions from the fee schedule. OBRA 1989 subjected portable x ray services to the 3 month delay in the MEI update, and payments for these services were not granted an MEI update after that. However, the conversion factors that applied to fees for portable x ray services in 1990 were equal to 100 percent of the conversion factors that applied in 1989, as opposed to 96 percent for all other radiology services. This meant that portable x ray services were not subject to the 4-percent reduction applied in 1990 to other services paid under the radiology fee schedule.

OBRA 1989 also granted a partial exemption from the fee schedule to physicians for whom nuclear medicine services consist of at least 80 percent of the physician's Medicare billings. In 1990, one-third of the payment was based on the fee schedule, with the remaining two-thirds based on 101 percent of the prevailing charge for the service.

The exemption from the prohibition on split billing granted to interventional and cardiovascular radiologists for 1989 was continued for 1990.

Finally, OBRA 1989 directed the Secretary to conduct a study of the costs of furnishing and payments for portable x ray services. The Secretary's report, which is due one year after enactment, is to contain recommendations concerning whether portable x ray services should be paid on the radiology fee schedule.

OBRA 1990 slowed the rate of transition to the RB RVS fee schedule in 1992 only for radiology services now paid under the separate radiology fee schedule. For other physician services, payments are reduced to the fee schedule amount unless the adjusted historical payment basis is greater than 115 percent of the fee schedule amount; in this case, the reduction is 15 percent. That provision was modified for payments to physicians now subject to the radiology fee schedule such that, if the historical payment basis exceeds 109 percent of the fee schedule, payment will be reduced by 9 percent in 1992.

OBRA 1990 reduced the 1991 conversion factor for radiology services (except portable x-ray services) by the lesser of 9.5 percent or the amount (if any) by which it exceeds the 1990 national weighted-average conversion factor, which is both reduced by 13 percent and adjusted for geographic differences in costs. In applying the geographic adjustments, the proportion attributable to physician work is different for the professional and technical components of radiology services. For the professional component of radiology services, 80 percent of the conversion factor is attributed to physician work. For the technical component, 0 percent is attributed to physician work.

OBRA 1990 further stipulated a floor for 1991 conversion factors; the minimum conversion factor is 60 percent of the national weighted average of conversion factors for 1990. OBRA 1990 also reduced payment for the technical component of magnetic resonance imaging (MRI) and computer axial tomography (CAT) scans by 10 percent, effective January 1, 1991.

OBRA 1990 extended for an additional year the exemption from the prohibition on split billing for interventional and cardiovascular radiologists for 1991. It also froze the transition to the RB RVS fee schedule for physicians for whom nuclear medicine services constitute at least 80 percent of the physician's Medicare billings. Under OBRA 1989, payments for these services were scheduled to be based two-thirds on the fee schedule and one-third on 101 percent of the 1988 prevailing charge. OBRA 1990 retained the payment system in effect in 1990—one-third on the fee schedule and two-thirds on 101 percent of the 1988 prevailing charge. OBRA 1990 also specified that prevailing charges for radiology services not paid under the fee schedule could not exceed fee schedule amounts.

PAYMENTS FOR PATHOLOGY SERVICES

OBRA 1987 required the Secretary to develop a fee schedule for payment of pathology services. The fee schedule was to be derived from a relative value scale and conversion factors, and could be applied on a regional, statewide or carrier service area basis.

Recent Legislative Changes

OBRA 1989 directed the Secretary to continue developing a separate fee schedule for pathology services, which was slated to be implemented on January 1, 1991. OBRA 1990 repealed the requirement for development of a separate pathlogy fee schedule, which means that pathology services will become part of the RB RVS fee schedule beginning in 1992. OBRA 1990 also reduced prevailing charges for pathology services in 1991 by 7 percent below the prevailing charges used in 1990, with one exception. Prevailing charges for the professional and technical components of pathology services furnished by a physician through an independent laboratory are not reduced if the reduction would result in prevailing charges less than 115 percent of the professional component of the service if furnished by a hospital-based physician in the same locality.

OBRA 1990 also directed the Secretary, in developing ancillary policies relating to development of relative values under the fee schedule, to consider an appropriate adjustment to reflect the technical component of physician pathology services furnished by laboratories independent of a hospital or the attending or consulting physician's office.

CLINICAL LABORATORY SERVICES

Since 1984, clinical diagnostic laboratory services have been reimbursed on the basis of a fee schedule established on a regional, statewide or carrier service area. As a matter of practice, the Secretary established the fee schedules on a carrier service basis. Reimbursement is based on reasonable charges, which are defined as the lowest of: (1) the actual charge; (2) an areawide fee schedule amount based on existing prevailing charge localities; and (3) a nationwide cap.

The fee schedule amount was originally set at 60 percent of the prevailing charge level in 1984 for physician and independent laboratories and at 62 percent of the prevailing charge for hospital-based laboratories. Both were scheduled to be adjusted annually by the Consumer Price Index for all urban consumers (CPI-U). The higher payment level for hospital-based laboratories was subsequently eliminated by OBRA 1987 except for sole community hospitals providing 24 hour a day emergency service. OBRA 1987 also reduced fees for specified high volume, automated tests by 8.3 percent.

The nationwide cap provision, implemented in 1986, was originally set at 115 percent of the median of the areawide fee schedule amounts. OBRA 1987 reduced the cap to 100 percent of the median areawide fee schedules. OBRA 1987 also eliminated the inflation update for 1988 and specified that future updates could not include amounts designed to catch up for the fact that no update was permitted in 1988. The update for 1989 was set at 4 percent.

When laboratory fee schedules first went into effect in 1984, implementation of a national fee schedule was slated for implementation July 1, 1988. That date was later postponed until January 1, 1990.

Physicians may only bill for clinical laboratory services on an assigned basis. Beginning January 1, 1988, physicians were prohibited from billing beneficiaries for lab services on an unassigned basis.

Congress enacted several measures designed to tie Medicare reimbursement to laboratory quality standards. In OBRA 1986, Congress stipulated that compliance with State licensure or other State standards qualified clinical laboratories for Medicare reimbursement. OBRA 1987 required high-volume physician office laboratories performing over 5,000 tests a year (including both Medicare and non-Medicare) to comply with the same standards required of independent laboratories. Prior to the passage of this provision, physician office laboratories were not generally regulated. The intent of this provision was to hold physician office laboratories doing a high volume of tests to the same standards imposed on independent laboratories.

Recent Legislative Changes

OBRA 1989 made several changes in Medicare reimbursement policy regarding clinical labs. In contrast to several other part B services which received no updates or reduced updates in 1990, payment under the laboratory fee schedule was updated by the CPI-U on January 1, 1990. This represents a 4.7-percent increase. At the same time, however, the national cap on fee schedules was reduced from 100 percent of the median of the areawide fee schedules to 93 percent of the median.

Prior to OBRA 1989's passage, payment for laboratory services could be made only to the person or entity that performed the test, except that if one laboratory performed the test at the request of another laboratory, payment could be made to the referring laboratory. OBRA 1989 added a restriction on payments to referring laboratories. Such payments could only be made if: (1) the referring laboratory is located in or is part of a rural hospital; (2) the referring laboratory is a wholly owned subsidiary of the lab performing the test, or both are wholly owned by a third party; and (3) not more than 30 percent of the lab tests for which the referring lab bills Medicare for are for tests performed by another laboratory.

OBRA 1989 also repealed two provisions of existing law: (1) the requirement for a nationwide fee schedule; and (2) the requirement that high volume physician office labs comply with the same standards imposed on independent labs. All laboratories must meet the certification requirements of the Clinical Laboratory Improvement Act of 1988.

OBRA 1990 specified that the update would be 2 percent for 1991, 1992, and 1993. It reduced the national cap on fee schedules from 93 percent of the national median of the areawide fee schedules to 88 percent of the median, effective January 1, 1991. It also clarified the mandatory assignment rule for laboratory services by specifically including lab tests performed in a physician's office.

PAYMENTS FOR PURCHASED SERVICES

In the past, physicians sometimes purchased certain diagnostic services from outside suppliers. That is, the outside supplier performed the technical component of the service, while the physician provided the professional service of interpreting the test results. The physician would bill the patient directly for these purchased services, sometimes in the form of a single global fee for both technical and professional components. In some cases, physicians billed fees that exceeded the sum of the reasonable charge for the professional component plus the actual cost of purchasing the technical component. In effect, these physicians increased their Medicare revenues by marking up the charge for the purchased service.

OBRA 1987 limited Medicare payment for purchased services effective January 1, 1989. The reasonable charge for the technical component of the service (the service actually purchased) is limited to the lesser of the actual acquisition cost and the outside supplier's reasonable charge for the service. When global fees are billed that include both technical and professional components, the reasonable charge is limited to the sum of the reasonable charges for the separate components. The Secretary is required to review the prevailing charges of diagnostic services that are commonly purchased and to reduce them if excessive. If the prevailing charge for a service is reduced, actual charges by nonparticipating physicians on unassigned claims are limited in the same manner as under inherent reasonable reductions.

ASSIGNMENT RATE EXPERIENCE

The total number of assigned claims as a percentage of total claims received by medicare carriers is known as the total assignment rate. The net assignment rate was computed in the same manner except that it omitted hospital-based physicians and group-practice prepayment plans which were considered assigned by definition (this distinction is no longer made). The net assignment rate declined since 1968, the year the Department of Health, Education, and Welfare (now the Department of Health and Human Services) began reporting this data. In the mid-1970's the rate leveled off at about 50 percent. Recently the rate has increased significantly. This reflects both the impact of the participating physician program as well as the requirement that laboratory services must be paid on an assigned basis. Chart 1 and table 3 show the net assignment rates for fiscal years 1969–1990.

CHART 1. NET ASSIGNMENT RATES, (1969–1990)

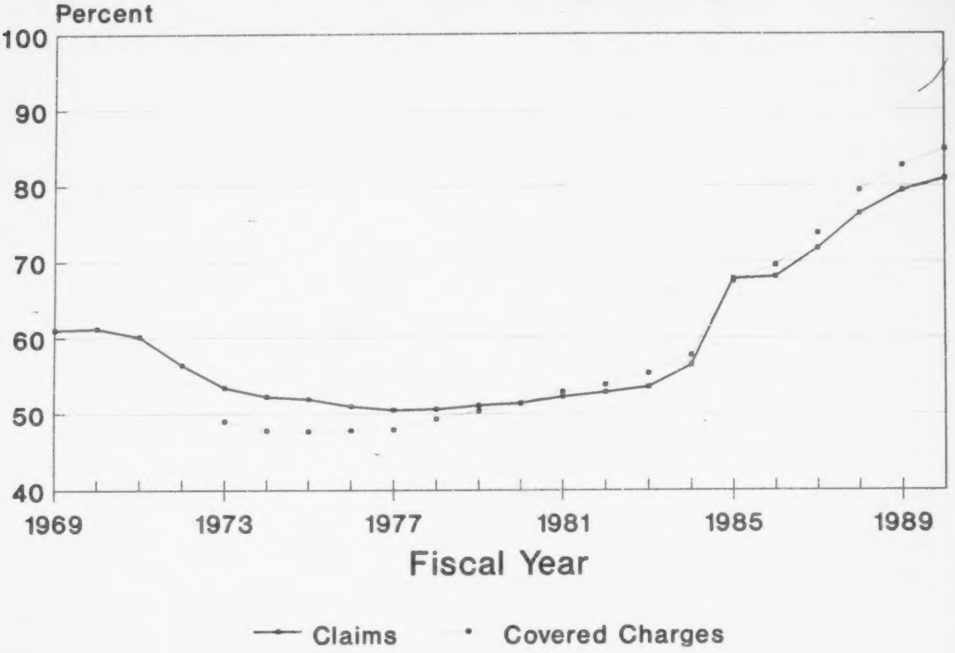


TABLE 3.—NET ASSIGNMENT RATES,[1] BY YEAR, 1969–90

[In percent]

Fiscal year	Claims	Covered Charges
1969	61.0	NA
1970	61.2	NA
1971	60.1	NA
1972	56.4	NA
1973	53.4	49.0
1974	52.2	47.8
1975	51.9	47.7
1976	51.0	47.8
1977	50.5	47.9
1978	50.6	49.3
1979	51.1	50.4
1980	51.4	51.3
1981	52.2	52.9
1982	52.8	53.8
1983	53.5	55.3
1984	56.4	57.7
1985	67.7	67.4
1986	68.0	69.5
1987	71.7	73.7

TABLE 3.—NET ASSIGNMENT RATES,[1] BY YEAR, 1969–90—Continued

[In percent]

Fiscal year	Claims	Covered Charges
1988	76.3	79.4
1989	79.3	82.6
1990	80.9	84.8

---

[1] Both measures of assignment exclude claims from hospital-based physicians and group-practice prepayment plans that are considered assigned by definition.

Source: U.S. Department of Health and Human Services.

TABLE 4.—PHYSICIAN ASSIGNMENT RATES AS PERCENT OF COVERED CHARGES BY STATE, FISCAL YEARS 1985–1990

[In percent]

Census division/State	Fiscal year—					
	1985 [1]	1986 [2]	1987 [3]	1988 [4]	1989	1990
National	65.5	66.4	70.8	77.0	80.6	83.0
New England:						
Maine	81.5	80.2	84.3	88.6	91.4	92.4
New Hampshire	56.5	55.0	58.3	64.3	67.8	69.9
Vermont	64.3	64.8	71.7	92.4	93.4	94.7
Massachusetts [5]	93.7	96.0	98.2	99.1	99.3	99.5
Rhode Island	94.0	94.4	95.1	96.0	97.1	98.7
Connecticut	57.6	55.0	62.8	72.5	80.4	84.7
Middle Atlantic:						
New York	70.3	71.4	73.9	78.5	81.1	81.9
New Jersey	62.3	62.4	63.8	67.4	70.4	73.0
Pennsylvania	88.1	89.8	91.0	93.4	94.9	95.7
East North Central:						
Ohio	50.8	50.6	58.8	71.0	77.8	82.6
Indiana	49.6	54.5	59.2	69.2	74.7	77.2
Illinois	51.7	55.0	59.9	67.5	72.4	75.9
Michigan	88.2	88.1	89.7	92.2	93.6	94.5
Wisconsin	51.7	50.8	54.6	61.3	65.6	68.2
West North Central:						
Minnesota	30.6	31.7	39.9	44.2	46.1	47.6
Iowa	46.9	47.6	53.2	62.6	67.5	69.8
Missouri	50.1	53.4	61.2	68.9	72.3	74.9
North Dakota	30.5	29.3	36.3	46.6	50.3	55.0
South Dakota	18.7	20.4	26.7	33.0	38.7	39.2
Nebraska	47.3	33.5	43.4	55.4	59.6	64.9
Kansas	72.7	73.7	78.7	84.6	87.2	88.8
South Atlantic:						
Delaware	81.8	79.8	81.9	84.6	88.1	90.5
Maryland	81.6	82.8	84.6	87.9	91.6	91.4

TABLE 4.—PHYSICIAN ASSIGNMENT RATES AS PERCENT OF COVERED CHARGES BY STATE, FISCAL YEARS 1985–1990—Continued

[In percent]

Census division/State	Fiscal year—					
	1985 [1]	1986 [2]	1987 [3]	1988 [4]	1989	1990
District of Columbia	78.1	78.6	80.5	84.6	86.5	87.5
Virginia	66.4	68.8	73.4	81.2	85.1	87.3
West Virginia	66.7	69.6	76.9	85.2	90.3	93.2
North Carolina	60.3	61.1	66.2	74.5	79.2	80.8
South Carolina	64.9	70.2	75.4	82.4	85.8	87.1
Georgia	63.9	64.8	69.1	75.5	80.5	83.5
Florida	62.2	64.8	68.6	76.1	80.3	84.1
East South Central:						
Kentucky	50.3	54.2	63.5	75.2	80.8	84.8
Tennessee	55.6	58.1	65.5	74.8	80.9	84.0
Alabama	74.6	75.8	91.7	87.4	90.1	92.3
Mississippi	63.5	67.3	73.5	80.5	85.4	88.1
West South Central:						
Arkansas	72.6	75.2	81.1	87.2	90.3	92.0
Louisiana	51.0	58.5	67.8	78.5	84.8	88.0
Oklahoma	39.0	39.8	48.6	58.5	66.0	68.2
Texas	63.0	61.1	67.2	74.2	78.0	79.9
Mountain:						
Montana	42.6	38.4	42.9	48.5	50.7	53.0
Idaho	25.2	24.8	26.4	30.0	33.7	36.1
Wyoming	33.8	32.1	30.4	36.7	40.2	43.9
Colorado	56.0	53.2	56.8	63.5	67.6	70.4
New Mexico	58.3	59.3	57.6	65.1	71.7	76.1
Arizona	52.8	51.2	57.1	66.6	72.0	76.2
Utah	63.1	61.4	69.4	74.1	79.9	80.4
Nevada	81.6	83.2	86.8	91.2	94.4	96.0
Pacific:						
Washington	45.5	47.9	46.6	46.4	50.8	54.8
Oregon	38.7	41.1	46.9	53.2	58.4	59.9
California	71.3	69.9	74.0	79.6	87.7	84.4
Alaska	54.4	55.9	64.3	73.9	78.5	79.6
Hawaii	61.2	64.5	72.0	76.8	80.7	82.9

---

[1] In instances in which carrier jurisdictions do not coincide with State boundaries, carrier rates were converted to State rates by calculating weights for the relevant counties based on their respective shares of total 1983 Medicare physician spending for physicians' services in the State and determining a weighted average rate. Rates reflect covered charges for physician claims processed during the period.

[2] The actual participation period was May through December 1986, and the participation agreements were in effect for that time.

[3] The actual participation period is January 1987 through March 1988, and the participation agreements are in effect for that time.

[4] The actual participation period is April 1988 through December 1988, and the participation agreements are in effect for that time.

[5] Massachusetts enacted a Medicare mandatory assignment provision, effective April 1986. The fact that the assignment rates shown here are not 100 percent may be explained by the inclusion in the data base of billings by practitioners other than allopathic and osteopathic physicians, which are included in the Medicare statutory definition of "physician".

The statistics included in table 3 are program-wide data. Assignment rates also vary geographically. For example, the assignment rate (taken as a percent of dollars) for physician services in fiscal year 1990 ranged from a low of 36.1 percent in Idaho to a high of 99.5 percent in Massachusetts. The national average assignment rate for physician services during this period was 83.0 percent (see table 4).

PARTICIPATING PHYSICIAN PROGRAM DATA

For the participation period beginning October 1, 1985, 27.9 percent of physicians billing Medicare were participating, 32.2 percent of limited license practitioners (i.e., chiropractors, dentists, podiatrists) were participating, and 23 percent of Medicare suppliers were participating. For the participation period beginning October 1, 1986, 28.4 percent of physicians (including limited license practitioners) were participating and 23.0 percent of suppliers were participating, for an overall participation rate of 27.7 percent.

As shown in tables 5 and 6, participation rates increased significantly for the April through December 1988 participation period. Participation rates for the 1989 and 1990 periods continued to show increases.

TABLE 5.—MEDICARE PHYSICIAN PARTICIPATION RATES: PERCENT OF PHYSICIANS WITH AGREEMENTS AND THEIR SHARE OF COVERED CHARGES

Participation period	Percent of physicians signing agreements	Participating physicians' covered charges as a percent of total [1]
October 1984–September 1985	30.4	36.0
October 1985–April 1986	28.4	36.3
April 1986–December 1986 [2]	28.3	38.7
January 1987–March 1988	30.6	48.1
April 1988–December 1988	37.3	57.9
January 1989–March 1990	40.2	62.0
April 1990–December 1990	45.5	67.2

[1] Rates reflect covered charges for physician services processed during period.

[2] The actual participation period was May through December of 1986, and participation agreements were in effect for that time. However, charge data are generally collected by quarter; thus, the data for the last three quarters of 1986 are used as a proxy for the participation period.

Source: Health Care Financing Administration.

TABLE 6.—PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS, BY SPECIALTY, FOR SELECTED PARTICIPATION PERIODS

Specialty	Oct. 1985–Apr. 1986	May 1986–Dec. 1986	Jan. 1987–Mar. 1988	Apr. 1988–Dec. 1988	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990
Physicians (M.D.s and D.O.s):						
General practice	27.3	23.6	25.6	32.3	35.8	39.7
General surgery	33.9	34.5	37.2	48.5	52.2	55.8
Otology, laryngology, rhinology	24.6	25.1	27.0	36.9	41.2	45.2
Anesthesiology	21.1	21.7	20.3	25.0	28.3	30.8
Cardiovascular disease	35.6	38.8	43.2	52.8	55.5	60.6
Dermatology	34.0	37.8	38.1	45.7	48.7	53.4
Family practice	25.5	27.1	27.1	35.6	39.7	47.2
Internal medicine	32.5	31.1	33.6	41.2	45.2	48.8
Neurology	34.8	33.2	39.2	44.1	49.2	53.1
Obstetrics-gynecology	29.1	30.5	31.5	40.4	44.2	48.8
Ophthalmology	27.3	28.7	35.1	46.3	50.5	55.6
Orthopedic surgery	29.0	38.3	32.6	44.0	49.2	53.7
Pathology	39.6	37.7	41.2	48.1	50.6	53.4
Psychiatry	30.0	27.8	28.6	34.4	37.8	41.6
Radiology	41.3	39.5	39.8	46.3	49.6	55.6
Urology	27.8	29.0	30.9	41.7	45.6	49.6
Nephrology	50.8	46.2	49.7	57.8	60.0	66.5
Clinic or other group practice—not GPPP	33.8	35.4	50.6	60.8	67.8	68.7
Other medical specialties	32.4	28.3	30.1	37.4		
Other surgical specialties	18.2	12.7	14.8	15.9		
Other physicians						29.2
Total physicians						45.5
Limited license practitioners (LLP):						
Chiropractor	25.4	23.8	19.7	22.9	24.8	26.2
Podiatry-surgical chiropody	38.2	31.8	33.4	44.6	52.6	54.0
Optometrist	44.0	48.2	44.1	50.5	48.9	54.0
Other limited license practitioners (audiologist, psychologist, physical therapist)	36.8	33.8	30.9	33.8	35.3	38.4
Certified registered midwife						15.2
Certified registered nurse anesthetist						12.5
Total limited license practitioners						40.0
Suppliers:						
Independent laboratory	28.4	36.3	37.2	42.0	20.1	45.4

TABLE 6.—PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS, BY SPECIALTY, FOR SELECTED PARTICIPATION PERIODS—Continued

Specialty	Oct. 1985–Apr. 1986	May 1986–Dec. 1986	Jan. 1987–Mar. 1988	Apr. 1988–Dec. 1988	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990
Durable medical equipment suppliers	22.7	18.7	16.6	19.2	30.1	21.7
Ambulance service suppliers	28.6	38.6	27.9	30.0	43.8	32.1
Miscellaneous suppliers (orthotists, prosthetists, portable x ray suppliers)	22.5	22.9	15.5	16.8	17.5	17.5
Total supplies						21.8

Source: Health Care Financing Administration.

Table 7 shows the percentage of participating physicians as a percentage of total physicians for each State. The national average of participating physicians as a percentage of total physicians continues to increase. In the October 1985 to April 1986 participation period, the percentage was 28.4. By the January 1989 to March 1990 participation period, this percentage had risen to 44.1.

TABLE 7.—PHYSICIAN AND LIMITED LICENSED PRACTITIONERS PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS, BY STATE AND PARTICIPATION PERIODS

State	Oct. 85–Apr. 86	May 86–Dec. 86	Jan. 87–Mar. 88	Apr. 88–Dec. 88	Jan. 89–Mar. 90	Apr. 90–Dec. 90
Alabama	58.2	63.0	68.8	73.5	75.9	74.6
Alaska	10.4	22.6	27.1	37.5	38.8	48.0
Arizona	15.4	18.5	28.1	38.7	41.2	53.5
Arkansas	45.2	34.7	42.0	50.9	53.1	53.9
California	30.0	39.7	38.9	48.5	54.0	57.7
Colorado	28.1	24.4	19.5	24.9	28.1	33.9
Connecticut	22.2	19.2	17.4	22.8	29.3	32.8
Delaware	23.9	29.7	31.2	37.4	37.5	42.5
District of Columbia	30.5	26.0	28.0	33.5	34.4	37.9
Florida	25.7	22.6	24.9	30.6	32.8	34.4
Georgia	33.1	27.9	25.8	32.5	49.7	49.5
Hawaii	20.6	41.7	47.8	53.7	53.7	56.8
Idaho	11.0	10.3	10.4	14.9	16.0	17.3
Illinois	23.1	21.8	26.7	36.4	40.0	42.3
Indiana	18.2	21.4	26.9	36.8	40.0	42.6
Iowa	29.7	38.2	25.1	43.7	45.3	48.1

TABLE 7.—PHYSICIAN AND LIMITED LICENSED PRACTITIONERS PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS, BY STATE AND PARTICIPATION PERIODS—Continued

State	Oct. 85–Apr. 86	May 86–Dec. 86	Jan. 87–Mar. 88	Apr. 88–Dec. 88	Jan. 89–Mar. 90	Apr. 90–Dec. 90
Kansas	45.4	39.5	51.4	60.0	61.6	57.1
Kentucky	24.3	28.0	34.2	46.4	50.5	56.4
Louisiana	18.8	13.4	18.1	29.5	32.6	34.6
Maine	35.4	28.5	34.2	42.4	51.2	48.7
Maryland	30.4	28.5	30.1	38.5	42.8	45.9
Massachusetts	48.1	43.0	43.8	45.9	46.9	50.5
Michigan	44.0	37.1	32.7	38.3	41.7	44.7
Minnesota	18.5	20.7	22.4	25.4	25.4	27.5
Mississippi	19.1	22.8	23.6	30.1	33.4	38.0
Missouri	35.2	24.0	24.5	29.5	39.6	45.7
Montana	24.3	13.9	17.0	19.9	21.5	23.4
Nebraska	20.0	23.8	25.7	48.2	42.5	49.2
Nevada	21.7	26.8	33.5	46.0	57.0	69.8
New Hampshire	26.9	27.2	25.9	28.4	28.0	30.9
New Jersey	18.0	20.6	22.7	28.2	26.0	27.6
New Mexico	17.7	13.8	30.8	25.9	36.3	45.6
New York	20.8	19.9	24.1	28.4	29.8	30.4
North Carolina	39.1	34.3	31.4	40.7	54.2	52.9
North Dakota	10.9	13.8	20.5	30.8	31.7	42.2
Ohio	21.7	26.4	28.9	41.8	46.8	50.8
Oklahoma	13.8	16.6	20.8	27.9	31.6	36.4
Oregon	18.5	22.8	26.1	32.8	36.9	41.7
Pennsylvania	50.8	45.6	32.1	36.6	39.0	42.1
Rhode Island	46.7	48.1	50.8	55.0	58.8	67.0
South Carolina	17.9	16.8	25.3	37.6	42.1	55.5
South Dakota	8.0	6.9	12.7	17.6	20.0	19.6
Tennessee	21.1	37.4	43.4	54.9	57.6	58.4
Texas	19.7	14.1	19.4	26.0	28.9	36.4
Utah	29.3	36.1	42.2	50.4	54.7	65.1
Vermont	41.5	38.2	34.1	38.5	40.5	43.8
Virginia	29.6	29.5	33.6	39.1	40.9	46.0
Washington	23.6	21.8	26.9	35.4	31.4	34.7
West Virginia	22.9	33.0	37.5	53.2	59.1	63.2
Wisconsin	31.0	37.5	35.1	39.0	40.0	46.5
Wyoming	18.3	16.9	20.3	20.1	19.3	34.6
National	28.4	28.3	30.6	37.3	40.7	44.1

Source: Health Care Financing Administration.

Table 8 shows the allowed charges of participating physicans as a percent of total allowed charges, by State for several participation periods. This percentage increased substantially over the last several participation periods. In the October 1984 to September 1985 period, it was 36 percent. It rose to 67.2 percent for the March, 1990 to December 1990 participation period.

TABLE 8.—COVERED CHARGES OF PARTICIPATING PHYSICIANS AS A PERCENT OF TOTAL COVERED CHARGES—BY STATE AND PARTICIPATION PERIOD [1]

[In percent]

Census division/State	Oct. 1984–Sept. 1985	Oct. 1985–Mar. 1986 [2]	Apr. 1986–Dec. 1986 [2]	Jan. 1987–Mar. 1988 [3]	Apr. 1988–Dec. 1988 [4]	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990
National	36.0	36.3	39.1	48.1	57.9	62.0	67.2
New England:							
Maine	50.9	50.4	54.0	64.8	75.3	79.4	80.5
New Hampshire	40.1	35.1	32.7	36.0	40.7	42.8	46.2
Vermont	37.3	36.0	39.8	46.8	72.3	81.4	85.9
Massachusetts	70.7	72.9	80.2	89.1	93.9	95.4	95.0
Rhode Island	68.7	77.1	79.6	85.8	88.4	88.8	95.2
Connecticut	30.7	32.3	35.9	45.3	58.0	65.9	67.9
Middle Atlantic:							
New York	31.5	33.2	36.0	40.8	47.7	51.7	58.0
New Jersey	21.5	24.3	26.4	32.8	41.8	42.3	49.6
Pennsylvania	71.4	69.9	69.2	75.1	80.6	81.6	87.9
East North Central:							
Ohio	24.9	27.2	28.5	41.5	56.7	61.9	70.9
Indiana	18.9	29.3	31.1	43.3	56.7	60.6	65.2
Illinois	29.4	31.3	32.4	42.0	53.5	58.1	61.8
Michigan	55.4	44.7	48.2	71.9	82.0	85.6	86.0
Wisconsin	31.3	21.2	30.5	31.7	31.0	42.7	48.9
West North Central:							
Minnesota	9.9	8.8	9.7	14.6	15.9	20.2	25.4
Iowa	28.5	29.4	30.5	41.0	50.0	54.2	57.8
Missouri	26.7	24.5	29.5	37.5	37.5	41.8	40.1
North Dakota	6.9	11.2	12.2	16.0	32.0	32.3	45.5
South Dakota	3.2	6.6	8.9	10.4	17.4	19.5	21.2
Nebraska	30.5	15.7	15.2	31.8	44.2	51.7	54.8
Kansas	48.0	42.5	41.7	NA	NA	82.5	82.3
South Atlantic:							
Delaware	57.0	55.8	54.9	58.5	67.1	70.8	76.6
Maryland	57.8	57.1	61.3	67.4	77.5	80.4	83.3
District of Columbia	60.3	61.3	60.8	66.6	71.7	73.9	76.8
Virginia	31.0	39.3	40.5	53.0	63.6	69.5	71.2
West Virginia	34.5	45.2	47.2	59.3	73.3	77.5	80.6
North Carolina	34.4	35.7	36.5	44.9	54.2	55.2	63.9
South Carolina	29.9	35.9	40.8	55.2	64.7	68.5	67.6
Georgia	29.3	32.5	35.1	43.0	54.3	50.7	65.9

TABLE 8.—COVERED CHARGES OF PARTICIPATING PHYSICIANS AS A PERCENT OF TOTAL COVERED CHARGES—BY STATE AND PARTICIPATION PERIOD [1]—Continued

[In percent]

Census division/State	Oct. 1984–Sept. 1985	Oct. 1985–Mar. 1986 [2]	Apr. 1986–Dec. 1986 [2]	Jan. 1987–Mar. 1988 [3]	Apr. 1988–Dec. 1988 [4]	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990
Florida	30.0	30.1	34.1	41.9	55.2	61.6	68.8
East South Central:							
Kentucky	22.3	25.0	26.3	44.7	59.0	64.3	72.6
Tennessee	25.1	25.2	26.7	41.3	56.6	57.4	68.5
Alabama	42.5	52.0	58.6	66.9	76.9	81.3	84.9
Mississippi	14.3	22.6	31.0	44.9	59.0	65.3	68.3
West South Central:							
Arkansas	47.9	47.6	53.6	68.3	76.6	81.0	84.5
Louisiana	16.2	19.4	32.9	48.2	63.7	71.0	76.7
Oklahoma	16.6	13.6	16.2	24.9	37.6	39.1	50.0
Texas	26.2	23.3	28.1	38.9	48.0	52.5	56.9
Mountain:							
Montana	25.6	19.1	20.1	23.8	27.4	29.9	29.7
Idaho	8.6	10.1	8.9	9.3	12.1	13.2	17.5
Wyoming	15.7	17.9	11.6	14.1	18.2	19.7	25.8
Colorado	23.5	29.3	28.9	34.0	42.7	47.7	50.5
New Mexico	34.1	31.0	30.6	28.1	36.8	39.5	51.1
Arizona	32.7	29.6	27.4	38.3	51.9	49.8	60.2
Utah	43.8	40.0	44.8	58.4	62.5	68.9	65.1
Nevada	41.5	57.6	58.0	63.4	72.9	69.9	82.1
Pacific:							
Washington	17.5	21.5	24.3	20.2	23.8	26.9	31.8
Oregon	17.3	15.7	16.7	25.5	35.4	34.8	43.3
California	42.2	40.2	42.5	50.2	62.0	67.2	71.2
Alaska	17.2	18.2	24.9	34.3	44.8	50.0	49.3
Hawaii	39.7	39.5	43.5	53.5	61.7	58.6	70.1

[1] In instances in which carrier jurisdictions do not concide with State boundaries, carrier rates were converted to state rates by calculating weights for the relevant counties based on their respective shares of total 1983 Medicare physician spending for physicians' services in the state and determining a weighted average rate. Rates reflect covered charges for physicians claims processed during the period.

[2] The actual participation period was May through December 1986, and the participation agreements were in effect for that time.

[3] The actual participation period is January 1987 through March 1988, and the participation agreements are in effect for that time.

[4] The actual participation period is April 1988 through December 1988 and the paticipation agreements are in effect for that time.

PARTICIPATION, ASSIGNMENT, AND REASONABLE CHARGE REDUCTIONS

The difference between the physician's billed charge and Medicare's approved or reasonable charge is referred to as the reasonable charge reduction. Reasonable charge reductions were made on 90.3 percent of unassigned claims in fiscal year 1990. The average amount of the reduction was 25.3 percent of billed charges, or $28.97 per approved claim. Beneficiaries are liable for these reduction amounts, although it is not known how often physicians actually collect from beneficiaries. The total reduced on all unassigned claims was $2,198.0 million in fiscal year 1990.

Through 1984, approximately the same proportions of assigned and unassigned claims were reduced (see table 9), and were reduced by similar proportions and amounts. Since 1984, the proportions of assigned and unassigned claims reduced have remained about the same, but the percentage and amounts of the reductions have diverged. The percent and dollar reductions on assigned claims have continued to increase while the percent and dollar reductions of unassigned claims have decreased. This pattern is due to the imposition of limits on the actual charges of nonparticipating physicians. That is, the MAAC limits, and the special limits on overpriced procedures have limited the rate of increase in prices for unassigned services relative to the overall increase in reasonable charges. The substantial growth in the overall percentage of services billed on an assigned basis also may have contributed to this pattern.

As a result, total beneficiary liability for charge reductions on unassigned claims has been falling. Total liability peaked in 1985 at $2,812.7 million, and declined by 22 percent to $2,198.0 million by 1990.

TABLE 9.—REASONABLE CHARGE REDUCTIONS FOR MEDICARE PART B (EXCLUDES CLAIMS FROM HOSPITAL-BASED PHYSICIANS AND GROUP-PRACTICE PREPAYMENT PLANS) FOR ASSIGNED AND NOT ASSIGNED CLAIMS, FISCAL YEARS 1975, 1980, AND 1984–1990

	1975	1980	1984	1985	1986	1987	1988	1989	1990
Percentage of claims reduced:									
Assigned	68.3	80.0	80.3	81.7	82.5	83.0	85.5	86.3	87.6
Not assigned	75.6	83.7	83.1	84.6	84.9	82.5	85.7	89.2	90.3
Percentage reduction in charges for covered services:									
Assigned	16.4	22.5	24.7	27.0	28.4	27.9	29.3	30.9	32.6
Not assigned	16.6	22.3	23.6	25.6	26.6	25.5	24.7	25.2	25.3
Amount reduced per approved claim:									
Assigned	$11.13	$21.81	$32.62	$33.19	$36.43	$36.98	$39.97	$43.72	$48.22
Not assigned	$13.45	$21.96	$29.69	$33.12	$33.15	$31.44	$29.47	$29.67	$28.97
Amount reduced on claims not assigned (in millions)	$450.1	$1,454.0	$2,698.2	$2,571.9	$2,812.5	$2,677.8	$2,312.6	$2,213.7	$2,198.0

Source: Department of Health and Human Services, Health Care Financing Administration.

The impact of reasonable charge reductions on unassigned claims is spread unevenly across the population. The most recent data available (March–December, 1990) show a 25.3 percent national average reduction on unassigned claims (see table 10). Beneficiary liability for these charge reductions ranged from a high of $250.4 million in California to a low of $.8 million in Vermont.

TABLE 10.—REASONABLE CHARGE REDUCTIONS FOR UNASSIGNED CLAIMS, BY STATE,[1] MARCH–DECEMBER, 1990

[Dollar amounts in millions]

Census division/State	Covered charges [2]		Percent reduction in unassigned charges	Amount reduced, unassigned charges [2]
	Total	Unassign		
National	$59,705.1	$8,783.0	25.3	$2,221.4
New England:				
Maine	225.6	15.2	23.0	3.5
New Hampshire	157.1	41.8	27.0	11.3
Vermont	80.5	4.0	24.3	1.0
Massachusetts [3]	1,671.5	12.1	23.1	2.8
Rhode Island	285.4	3.5	22.6	.8
Connecticut	906.2	123.9	24.6	30.5
Middle Atlantic:				
New York	4,928.4	827.0	29.6	248.2
New Jersey	2,073.8	472.8	23.1	109.4
Pennsylvania	4,180.7	141.0	21.5	30.4
East North Central:				
Ohio	2,583.1	393.1	23.3	91.6
Indiana	1,006.0	213.1	24.6	52.5
Illinois	2,278.0	491.0	25.2	123.9
Michigan	2,222.0	119.0	26.2	31.2
Wisconsin	876.6	248.7	23.2	57.8
West North Central:				
Minnesota	593.6	278.9	27.1	74.9
Iowa	479.1	133.5	25.6	34.2
Missouri	1,193.1	230.8	22.4	51.3
North Dakota	155.6	59.3	26.4	15.7
South Dakota	133.3	70.2	26.5	18.6
Nebraska	272.8	86.9	21.3	18.5
Kansas	381.7	39.5	22.8	8.9
South Atlantic:				
Delaware	151.2	12.0	20.9	2.5
Maryland	1,097.0	82.5	24.3	20.0
District of Columbia	318.2	34.6	23.5	8.1
Virginia	998.1	117.8	25.1	29.5
West Virginia	429.1	25.6	27.3	7.0
North Carolina	1,350.5	217.0	26.7	57.9
South Carolina	523.7	62.3	25.9	16.2
Georgia	1,189.4	171.5	25.1	43.1
Florida	5,388.8	743.2	18.1	134.7

TABLE 10.—REASONABLE CHARGE REDUCTIONS FOR UNASSIGNED CLAIMS, BY STATE,[1] MARCH-DECEMBER, 1990—Continued

[Dollar amounts in millions]

Census division/State	Covered charges [2]		Percent reduction in unassigned charges	Amount reduced, unassigned charges [2]
	Total	Unassign		
East South Central:				
Kentucky	769.2	91.2	24.7	22.6
Tennessee	1,147.4	151.5	26.4	40.1
Alabama	818.7	53.9	27.4	14.8
Mississippi	477.0	50.3	26.7	13.4
West South Central:				
Arkansas	560.2	41.5	23.2	9.6
Louisiana	984.5	105.0	25.7	27.0
Oklahoma	605.8	163.8	27.7	45.3
Texas	3,303.02	580.0	28.4	164.6
Mountain:				
Montana	126.0	54.1	22.4	12.1
Idaho	119.0	71.0	26.5	18.8
Wyoming	38.8	18.6	26.1	4.8
Colorado	441.8	109.0	22.8	24.9
New Mexico	216.1	38.1	24.5	9.4
Arizona	835.0	173.8	25.1	43.6
Utah	182.8	31.3	25.0	7.8
Nevada	301.3	11.9	24.9	3.0
Pacific:				
Washington	815.6	278.0	24.3	66.0
Oregon	446.1	154.1	23.0	35.4
California	6,344.1	868.1	28.8	250.4
Alaska	33.3	5.9	26.1	1.5
Hawaii	159.1	24.8	28.2	7.0

---

[1] In instances in which carrier jurisdictions do not coincide with State boundaries, carrier rates were converted to State rates by calculating weights for the relevant counties based on their respective shares of total 1983 Medicare physician spending for physicians' services in the State and determining a weighted average rate. Rates reflect covered charges for physician claims processed during the period. National data include data for Puerto Rico, the Virgin Islands, the Railroad Retirement Board, and Parenteral and Enteral Claims. Therefore the sum of the State data will not equal the national total.

[2] Amounts in millions.

[3] Massachusetts enacted a Medicare mandatory assignment provision, effective April 1986. The fact that the assignment rates shown here are not 100 percent may be explained by the inclusion in the database of billings by practitioners other than allopathic and osteopathic physicians, which are included in the Medicare statutory definition of "physician".

The changing pattern of reasonable charge reductions is due, in part, to overall changes in participation and assignment rates. As shown in table 11, participating physicians account for a growing share of total physician charges. During the first participation period (fiscal year 1985), participating physicians (30.4 percent of all physicians) accounted for 36.0 percent of all physician charges. According to the most recent data available (March-December 1990), the proportion of physicians participating has grown to 44.1

percent, and account for over half (67.2 percent) of all physician charges. Net assignment rates have also increased for nonparticipating physicians, as shown in table 8. The proportion of charges billed by participation and assignment status varies by State; these data are shown in table 12.

TABLE 11.—DISTRIBUTION OF COVERED CHARGES FOR SERVICES BILLED, BY PARTICIPATION STATUS OF PHYSICIAN AND ASSIGNMENT STATUS OF CLAIM [1]

[In percent]

Time period	Total	Participants	Nonparticipants	
			Assigned	Unassigned
Oct. 1984–Sept. 1985	100.0	36.0	29.5	34.5
Oct. 1985–Mar. 1986	100.0	36.3	29.4	34.3
Apr. 1986–Dec. 1986 [2]	100.0	39.1	28.0	32.9
Jan. 1987–Mar. 1988 [3]	100.0	48.1	25.2	26.7
Apr. 1988–Dec. 1988	100.0	57.9	21.0	21.1
Jan. 1989–Mar. 1990	100.0	62.0	19.5	18.5
Apr. 1990–Dec. 1990	100.0	67.2	16.7	16.1

[1] Rates reflect covered charges for physician claims processed during the period. Data for up to seven carriers missing from various quarters.

[2] The actual participation period was May through December 1986, and the participation agreements were in effect for that time.

[3] The actual participation period is January 1987 through March 1988, and the participation agreements are in effect for that time.

TABLE 12.—DISTRIBUTION OF COVERED CHARGES FOR SERVICES BILLED, BY PARTICIPATION STATUS OF PHYSICIAN AND ASSIGNMENT STATUS OF CLAIM, BY STATE, APRIL–DECEMBER 1990 [1]

Census division/State	Total	Participating physician	Nonparticipating physician	
			Assigned	Unassigned
National	100.0	67.2	16.7	16.1
New England:				
Maine	100.0	80.8	12.0	7.2
New Hampshire	100.0	46.2	25.5	28.3
Vermont	100.0	85.9	9.6	4.5
Massachusetts	100.0	95.6	3.9	.5
Rhode Island	100.0	95.2	4.3	.5
Connecticut	100.0	67.9	16.7	16.1
Middle Atlantic:				
New York	100.0	58.0	24.5	17.5
New Jersey	100.0	49.6	24.3	26.1
Pennsylvania	100.0	87.9	8.9	3.2
East North Central:				
Ohio	100.0	70.9	13.3	15.8
Indiana	100.0	65.2	13.3	21.5
Illinois	100.0	61.8	14.9	23.4
Michigan	100.0	86.0	8.3	5.7
Wisconsin	100.0	48.9	20.7	30.4

TABLE 12.—DISTRIBUTION OF COVERED CHARGES FOR SERVICES BILLED, BY PARTICIPATION STATUS OF PHYSICIAN AND ASSIGNMENT STATUS OF CLAIM, BY STATE, APRIL–DECEMBER 1990 [1]—Continued

Census division/State	Total	Participating physician	Nonparticipating physician	
			Assigned	Unassigned
West North Central:				
Minnesota	100.0	25.4	23.8	50.8
Iowa	100.0	57.8	13.3	28.9
Missouri	100.0	40.1	35.6	24.2
North Dakota	100.0	45.5	15.4	39.1
South Dakota	100.0	21.2	18.4	60.4
Nebraska	100.0	54.8	12.2	32.9
Kansas	100.0	82.3	7.2	10.4
South Atlantic:				
Delaware	100.0	76.6	14.9	8.5
Maryland	100.0	83.3	8.6	8.1
District of Columbia	100.0	76.8	11.1	12.0
Virginia	100.0	71.2	16.7	12.1
West Virginia	100.0	80.6	13.4	6.0
North Carolina	100.0	63.9	17.3	18.9
South Carolina	100.0	67.6	19.6	12.8
Georgia	100.0	65.9	18.1	16.0
Florida	100.0	68.8	16.7	14.5
East South Central:				
Kentucky	100.0	72.6	14.5	12.9
Tennessee	100.0	68.5	17.9	13.7
Alabama	100.0	84.9	8.3	6.8
Mississippi	100.0	68.3	20.9	10.8
West South Central:				
Arkansas	100.0	84.5	8.1	7.4
Louisiana	100.0	76.7	12.5	10.8
Oklahoma	100.0	50.0	19.3	30.7
Texas	100.0	56.9	23.9	19.3
Mountain:				
Montana	100.0	29.7	22.3	47.9
Idaho	100.0	17.5	19.4	63.2
Wyoming	100.0	25.8	19.8	54.3
Colorado	100.0	50.5	20.3	29.2
New Mexico	100.0	51.1	26.7	22.2
Arizona	100.0	60.2	16.3	23.6
Utah	100.0	65.1	11.8	23.1
Nevada	100.0	82.1	14.3	3.6
Pacific:				
Washington	100.0	31.8	25.1	43.1
Oregon	100.0	43.3	17.3	39.4
California	100.0	71.3	14.0	14.5
Alaska	100.0	49.9	31.1	18.9
Hawaii	100.0	70.0	13.9	16.1

---

[1] In instances in which carrier jurisdictions do not coincide with State boundaries, carrier rates were converted to State rates by calculating weights for the relevant counties based on their respective shares of total 1983 Medicare physician spending for physicians' services in the State and determining a weighted average rate. Rates reflect covered charges for physicians claims processed during the period.

DISTRIBUTION OF PHYSICIAN SERVICES

The following tables show the distribution of "reasonable charges" or allowed amounts under the CPR system for calendar year 1989 by various categories of services. The figures are tabulations from the 1989 Part B Medicare Annual Data Procedure file, which is a summary of all claims filed with the Medicare carriers.

The totals shown will differ from total SMI outlay figures for 1989 shown in the budget for several reasons:

The amounts shown in these tables are allowed amounts, rather than reimbursements—that is, they include both Medicare's and the enrollee's share of reasonable charges.

The amounts shown are for services rendered during calendar year 1989; budget figures are for payments made during the year (sometimes calendar and sometimes fiscal year) regardless of when the services were rendered.

The amounts shown are only for services reimbursed by carriers under the CPR system; hence, they do not include Part B payments to hospital outpatient departments or to risk-based prepaid medical plans.

Further, the amounts shown underestimate what they are supposed to represent by a small amount because some claims for services rendered in 1989 had not been processed by carriers at the time the 1989 files were submitted to HCFA, and because some claims recorded had to be eliminated due to recording errors.

Table 13 illustrates that in 1989, 82.7 percent of allowed amounts under the CPR system were for physicians' services, and another 2.8 percent were for the services of limited license practitioners—psychologists, podiatrists, optometrists, audiologists, chiropractors, dentists, and physical therapists. Almost 4 percent went to independent laboratories in 1989, while 10.8 percent went to suppliers of medical equipment, prosthetics, and ambulance services.

TABLE 13.—ALLOWED AMOUNTS FOR CPR CLAIMS, BY TYPE OF PROVIDER, 1989

Type of provider	Allowed amounts (millions)	Percent of total	Percent inpatient
Physicians	$28,724	82.7	44.8
Limited license practitioners [1]	971	2.8	2.3
Laboratories	1,279	3.7	.3
Medical suppliers [2]	3,767	10.8	3.9
All providers [3]	$34,740	100.0	37.6

[1] Includes psychology, podiatry, optometry, audiology, chiropractice, dentistry, and physical therapy.

[2] Includes suppliers of medical equipment, prosthetics, and ambulance services.

[3] Total does not include charges for hospital outpatient department facility fees or for risk-based prepaid medical plans since these are not reimbursed under the CPR system.

Source: HCFA, Bureau of Data Management and Strategy, Data from the Part B Medicare Annual Data System.

About 38 percent of all CPR allowed amounts were for hospital inpatient services, and almost 45 percent of allowed amounts for physicians' services were inpatient. The share of physicians' services that are inpatient has dropped in recent years, from nearly 64 percent in 1981.

Table 14 shows the distribution of spending for physicians' services by specialty. (It excludes limited license practitioners, labs, and suppliers.) In 1989, generalists accounted for 31.2 percent of spending, nonsurgical specialists for 18.5 percent, and surgical specialists for 35 percent. Radiologists, anesthesiologists, and pathologists (RAPs) together accounted for 15 percent of allowed amounts. Osteopathic physicians accounted for less than 1 percent of total allowed amounts for physicians' services.

The major physician specialties treating the Medicare population, in descending order of importance as measured by total allowed amounts, were general internists (17 percent of allowed amounts), ophthalmologists (12 percent), radiologists (10 percent), general surgeons (nearly 7 percent), and cardiologists (8 percent).

The share of services provided on an inpatient basis varied by specialty, generally increasing with specialization. About 37 percent of the services of generalists were inpatient in 1989. The inpatient share was 54 percent for nonsurgical specialists and 46 percent for surgical specialists.

Table 15 shows the distribution of spending for physicians' services by type of service. About 34 percent of spending was for medical care (nonsurgical) in 1989. About 41 percent of spending was for surgical procedures in total, adding together the amounts for surgeons, assistant surgeons, and anesthesiologists. About 11 percent was for diagnostic laboratory tests, which would include not only blood chemistry analysis and urinalysis, but also tests such as EKGs. Nearly 11 percent of spending was for radiology, and almost 4 percent was for consultations.

TABLE 14.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY PHYSICIAN SPECIALTY, 1989

Specialty	Allowed amounts (millions)	Percent of total		Percent inpatient	
	1989	1987	1989	1987	1989
Generalists:					
General practice	$1,066	4.4	3.8	26.2	21.8
Family practice	1,396	4.4	4.9	30.8	27.6
Internal medicine	4,903	17.6	17.1	46.1	42.5
Pediatrics	23	.1	.1	25.5	23.7
Clinics	1,548	5.9	5.4	42.4	38.8
All generalists	8,955	32.3	31.2	40.6	37.0
Nonsurgical specialists:					
Allergy	44	.1	.2	8.2	7.9
Cardiology	2,234	6.8	7.8	66.4	64.0
Dermatology	522	1.7	1.8	2.0	1.7
Gastroenterology	747	2.2	2.6	52.5	48.5
Neurology	398	1.4	1.4	57.5	53.7
Psychiatry	415	1.3	1.4	87.8	61.6
Physical medicine	137	.4	.5	61.9	62.3
Pulmonary disease	457	1.4	1.6	73.9	71.9
Geriatrics	11	(1)		43.1	36.7
Nephrology	359	1.1	1.3	64.0	55.0
All nonsurgical specialists	5,325	16.5	18.5	56.3	54.3
Surgical specialists:					
General surgery	2,013	7.6	7.0	76.5	73.0
Otolaryngology	320	1.1	1.1	29.8	24.6
Neurosurgery	261	.9	.9	86.8	86.2
Gynecology	211	.7	.7	55.9	51.5
Ophthalmology	3,520	12.9	12.3	7.8	6.2
Orthopedic surgery	1,482	5.2	5.2	87.8	64.4
Plastic surgery	148	.5	.5	42.7	37.6
Colon and rectal surgery	64	.2	.2	43.4	38.4
Thoracic surgery	966	3.3	3.3	93.0	92.1
Urology	1,030	3.7	3.6	64.8	55.4
Hand surgery	8	(1)		43.2	33.7
All surgical specialists	10,013	36.1	34.9	48.6	45.8
Radiology	2,755	9.2	9.6	40.2	34.7
Anesthesiology	1,186	4.5	4.1	78.8	76.2
Pathology	375	1.2	1.3	61.3	54.4
Osteopathy	114	.4	.4	26.4	23.0
All physicians	26,724	100.0	100.0	47.9	44.8

[1] Less than 0.05 percent.

Source: HCFA, Bureau of Data Management and Strategy, Data from the part B Medicare Annual Data System.

TABLE 15.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY TYPE OF SERVICE, 1989

Type of service	Allowed amounts (millions)	Percent of total		Percent inpatient	
	1989	1987	1989	1987	1989
Medical care	$9,888	33.9	34.4	43.0	41.2
Surgery	9,919	35.2	34.5	56.7	53.7
Assistance at surgery	346	1.2	1.2	90.9	90.2
Anesthesia	1,101	4.4	3.8	78.7	76.2
Diagnostic laboratory tests	2,394	7.4	8.3	24.5	23.0
Diagnostic radiology	3,083	10.0	10.7	35.9	32.2
Therapeutic radiology	481	1.5	1.7	11.5	9.1
Consultations [1]	1,016	4.5	3.5	68.5	69.6
Other [2]	495	2.0	1.7	10.3	6.6
All services	28,724	100.0	100.0	47.9	44.8

[1] Includes first and second opinions for surgery.

[2] Includes treatment for renal patients, pneumococcal vaccine, and medical supplies, among other things.

Source: HCFA.

Table 16 lists the top 20 individual services, ranked by total allowed amounts on claims submitted by selected physicians for 1989. The most important exclusion is amounts for the services of anesthesiologists, since there would typically be a charge for anesthesiology for the surgical procedures. The amounts for surgical procedures include claims by both the primary surgeon and any assistant surgeons, but not the amounts for anesthesiologists.

The top 20 services (out of more than 7,000) accounted for more than 35 percent of all spending for all physicians' services in 1989. Cataract extraction with implantation of an intraocular lens was the top-ranked procedure, accounting by itself for more than 6 percent of total allowed amounts for physicians' services. Other surgical procedures in the top 20 included transurethral resections of the prostate (TURP), coronary artery bypass surgery, and knee arthroplasty. The remaining services in the top 20 were either visits, consultations, or EKGs.

Table 17 presents total allowed amounts for selected groups of generic services, and shows the percent of total allowed amounts for all physicians' services accounted for by each group. As in table 16, certain physicians' services—most notably for anesthesiologists—are not included in the allowed amounts for each service group. No attempt was made to define and rank all possible service groups, so that there may be other important service groups that do not appear in the table. For example, diagnostic radiology accounts for 10 percent of allowed amounts for physicians' services (from table 11), but radiological services do not appear in table 17.

TABLE 16.—THE TOP 20 SERVICES BILLED BY PHYSICIANS UNDER MEDICARE, 1989

Service code and description	Allowed amounts (millions) [1]	Percent of total
Top 20 services:		
66984—Cataract extraction and IOL	$1,753	6.1
90060—Office visit, intermediate	1,312	4.6
90050—Office visit, limited	1,033	3.6
90260—Hospital visit, intermediate	1,014	3.5
90250—Hospital visit, limited	663	2.3
90620—Consultation, comprehensive	546	1.9
90220—Initial hospital visit, comprehensive	473	1.6
93000—EKG (12 leads)	360	1.3
90070—Office visit, extended	357	1.2
90270—Hospital visit, extended	317	1.1
66821—After cataract	278	1.0
52601—TURP	255	.9
93010—EKG, interpretation and report only	244	.9
90080—Office visit, comprehensive	233	.8
90040—Office visit, brief	224	.8
92014—Ophthalmological exam & eval, comprehensive	218	.8
45378—Colonoscopy	210	.7
90020—Office visit, comprehensive, new patient	208	.7
27447—Knee arthroplasty	200	.7
33512—Coronary artery bypass (3)	192	.7
Total	10,090	35.1

[1] Amounts for surgical procedures include fees for primary and assistant surgeons, but not for anesthesiologists.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy. Data from the part B Medicare Annual Data System.

The 21 service groups shown in table 17 accounted for 43 percent of all allowed amounts for all physicians' services in 1989. The single most costly group was for office visits (accounting for over nearly 13 percent of total allowed amounts for physicians' services), followed by hospital visits (10 percent). Cataract surgery of all types accounted for more than 6 percent of total allowed amounts for physicians' services. EKGs accounted for 2.5 percent of total allowed amounts when all codes for the procedure are considered. It should also be noted that the amount for hemodialysis includes only physician services and does not include the much larger amounts for the facility charges for hemodialysis that are not billed under the CPR reimbursement system.

TABLE 17.—ALLOWED AMOUNTS FOR SELECTED GROUPS OF PHYSICIANS' SERVICES, 1989

Service group	Allowed charges (millions) [1]	Percent of total
Office visits (90000–90080)	$3,610	12.6
Hospital visits (90200–90282)	2,876	10.2
Cataract surgery (66830–66985)	1,845	6.4
EKG's (93000–93105, 93258–92366, 99150, 99151)	725	2.5
Coronary artery bypass (33510–33528)	559	1.9
Colonoscopy (45378–45385, 44388–44393, 45355)	487	1.7
Cardiac catheterization (93501–93562)	475	1.7
Emergency room visits (90500–90580)	413	1.4
Transurethral surgery (52601)	255	.9
Knee arthroplasty (27446, 27447, 29881)	234	.8
SNF visits (90300–90370)	185	.6
Hip arthroplasty (27130–27132)	172	.6
Pacemaker implant/removal (33200–33210, 33232)	116	.4
Thromboendarterectomy (35301–35381)	111	.4
Nursing home visits (90400–90470)	97	.3
Vein bypass (35501–35587)	81	.3
Home visits (90100–90170)	57	.2
Prostatectomy (55801–55845)	40	.1
Pacemaker tests (93731–93736)	38	.1
EEG's (95819–95851, 99150–99151)	36	.1
Hemodialysis/capd (90941–90958)	32	.1
Total	12,446	43.3

[1] Amounts for surgical procedures include fees for primary and assistant surgeons, but not for anesthesiologists.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy. Data from the part B Medicare Annual Data System.

During the 1980s, there have been many changes in the delivery of health care services. Some of the more significant changes affecting Medicare services have been in the delivery of surgical services. First, there has been significant growth in the amount of surgical care provided by some specialties. Second, there has been a dramatic shift in the place of surgical care; that is, surgical care is now frequently provided in outpatient settings whereas previously, most surgical care was provided in inpatient settings.

TABLE 18.—CHARGES SUBMITTED TO MEDICARE FOR ALL PHYSICIAN SURGICAL SERVICES, BY PLACE OF SERVICE, 1980 AND 1989

Place of service	Surgical charges [1]		
	Amount in millions	Percent of surgical charges	As percent of total settings charges
1980:			
Total	$3,828	100.0	31.8
Office	445	11.6	12.2
Outpatient hospital	129	3.3	29.5
Inpatient hospital	3,231	84.4	44.1
Other [2]	23	.6	3.7
1989:			
Total	10,280	100.0	34.0
Office	1,768	17.2	16.4
Outpatient hospital [1]	2,646	25.7	55.1
Inpatient hospital	5,345	52.0	41.0
ASC	416	4.0	52.1
Other [2]	105	1.0	13.3

[1] Amounts shown represent submitted charges prior to "reasonable charge" reductions.

[2] Includes homes, nursing homes, and other places of service, and in 1987 ambulatory surgical centers.

Source: Health Care Financial Administration, Bureau of Data Management and Strategy, part B Carrier Statistical System.

As shown in table 18, the most significant shift in site of surgical care between 1980 and 1989 was out of inpatient settings and into other settings. Outpatient hospital setting benefited most from this shift, growing from only 3.3 percent of all surgical charges in 1980 to 25.7 percent in 1989. The proportions of surgery taking place in a physician's office and in other nonhospital settings also grew somewhat. In 1989, 52 percent of all surgical care was provided in inpatient settings.

Table 19 shows the percent of total surgical charges by specialty in 1980 and 1989. In 1980, four specialties (ophthalmology, general surgery, orthopedic surgery and urology) accounted for nearly 60 percent of all Medicare surgical care. These same four specialties accounted for nearly the same proportion of total surgical care in 1989, but the shares among these specialties changed. While ophthalmologists accounted for only 13.6 percent in 1980, by 1989 their share had nearly doubled to 24.7 percent due primarily to the substantial growth in cataract surgery during the 1980s. For three specialties (ophthalmology, gastroenterology, and otology, laryngology and rhinology or ENT), surgical care represented much larger proportions of their total Medicare practice in 1989 than in 1980.

TABLE 19.—SUBMITTED SURGICAL CHARGES UNDER MEDICARE AS A SHARE OF TOTAL SURGICAL CHARGES AND AS A PERCENT OF TOTAL PRACTICE CHARGES, BY MEDICAL SPECIALTY, 1980 AND 1989

Specialty	Percent distribution of surgical charges		Surgical charges as a percent of total practice charges	
	1980	1989	1980	1989
All physicians	100.0	100.0	31.8	34.0
Ophthalmology	13.6	24.7	62.1	72.3
General surgery	22.1	14.6	71.6	74.7
Orthopedic surgery	13.0	10.4	73.6	72.1
Urology	10.7	6.9	75.6	68.7
Thoracic surgery	8.0	7.7	82.2	82.4
Clinic or other group practice	4.7	3.6	25.8	23.6
Internal medicine	4.2	4.3	6.9	9.1
Cardiovascular disease	2.7	4.8	22.4	22.1
Podiatry	3.0	3.4	53.5	62.8
Gastroenterology	1.7	5.0	45.9	69.3
Dermatology	2.4	3.5	60.9	69.5
Neurological surgery	2.9	2.0	70.2	76.9
Othology, laryngology, rhinology	1.9	.2	49.7	70.6
Plastic surgery	1.3	1.3	88.1	87.0
Other	8.4	7.7	....	7.7

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, part B Carrier Statistical System.

As shown in table 20, many different medical specialties participated in the shift to outpatient surgery. In 1980, only two specialties (dermatology and podiatry) performed the majority of their surgical services in outpatient settings; in these cases, the care was generally provided in the physician's office. In 1989, six specialties provided a majority of their surgical care in outpatient settings: ophthalmology, podiatry, gastroenterology, dermatology, ENT and plastic surgery. While podiatrists and dermatologists continued primarily to work in their offices, the other specialties provided their surgical services in outpatient hospital and ambulatory surgical facilities. Most surgical specialties, such as general, orthopedic, cardiovascular, neurological and thoracic surgeons, remained closely tied to inpatient hospital settings.

TABLE 20.—SUBMITTED SURGICAL CHARGES UNDER MEDICARE, BY MEDICAL SPECIALTY AND PLACE OF SERVICE, 1980 AND 1989

[In percent]

Specialty	1980					1989					
	All settings	Office	Inpatient hospital	Outpatient hospital	Other [1]	All settings	Office	Inpatient hospital	Outpatient hospital [2]	ASC [3]	Other [1]
All physicians	100.0	11.6	84.4	3.3	0.5	100.0	17.2	52.0	25.7	4.1	1.0
Ophthalmology	100.0	7.9	87.1	5.0	.1	100.0	16.3	7.8	60.2	15.0	.7
General surgery	100.0	4.4	92.6	2.9	.1	100.0	6.0	80.6	12.7	.3	.4
Orthopedic surgery	100.0	6.3	90.2	3.4	.1	100.0	7.4	80.8	11.7	.4	.2
Urology	100.0	8.0	90.6	1.4	.1	100.0	16.4	70.2	13.0	.3	.2
Thoracic surgery	100.0	.8	98.7	.5	(4)	100.0	1.1	97.2	1.6	(4)	.1
Clinic and other group practice	100.0	10.1	85.3	4.5	.1	100.0	15.2	61.4	22.5	.5	.4
Internal medicine	100.0	17.5	76.6	5.7	.2	100.0	24.9	48.0	26.1	.5	.5
Cardiovascular disease	100.0	1.7	97.9	.4	(4)	100.0	1.5	94.1	4.3	(4)	.1
Podiatry	100.0	71.3	13.5	.9	14.3	100.0	70.3	2.8	7.1	1.0	18.8
Gastroenterology	100.0	12.0	75.6	12.3	.1	100.0	11.9	43.6	42.9	1.8	.4
Neurological surgery	100.0	1.1	98.5	.5	(4)	100.0	1.5	95.6	2.8	0.0	(4)
Dermatology	100.0	94.6	4.0	.9	.6	100.0	97.8	.8	1.0	.1	.3
Otology, laryngology, rhinology	100.0	12.6	83.7	3.7	(4)	100.0	17.1	5.7	74.5	2.5	.2
Plastic surgery	100.0	13.0	67.2	19.7	.1	100.0	20.2	38.9	37.1	3.0	.1
Obstetrics/Gynecology	100.0					100.0	11.3	77.8	10.9	.3	.2
Other	100.0					100.0	26.6	50.2	21.8	.8	.6

[1] Includes homes, nursing homes, and other places of service.
[2] May include some services rendered in an ambulatory surgery center.
[3] Ambulatory surgical center.
[4] Less than .05.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, data from the part B Carrier Statistical System.

TABLE 21.—PERCENT DISTRIBUTION OF ALLOWED SURGICAL CHARGES UNDER MEDICARE, BY SELECTED SPECIALTIES AND SELECTED PLACE OF SERVICE, 1989

Place of service	Percent
Inpatient hospital:	
General surgery	22.7
Orthopedic surgery	16.1
Thoracic surgery	14.3
Urology	9.3
Cardiovascular disease	8.7
Clinic and other group practice	4.2
Gastroenterology	4.2
Internal medicine	4.0
Ophthalmology	3.7
Neurological surgery	3.6
Other medical and surgical specialties	9.2
Total	100.0
Office:	
Ophthalmology	23.5
Dermatology	20.1
Podiatry	13.8
Urology	6.5
Internal medicine	6.3
General surgery	5.1
Orthopedic surgery	4.5
Gastroenterology	3.5
Family practice	3.1
Clinic and other group practice	3.1
Other medical and surgical specialties	10.5
Total	100.0
Outpatient hospital:	
Ophthalmology	57.8
Gastroenterology	8.4
General surgery	7.2
Orthopedic surgery	4.7
Internal medicine	4.4
Urology	3.5
Clinic and other group practice	3.1
Otology, larynology, rhinology	1.8
Plastic surgery	1.8
Other medical and surgical specialties	7.3
Total	100.0

Source: Health Care Financing Administration, Bureau of Data Management and Strategy. Data from the part B Medicare Annual Data System.

In 1989, ophthalmologists provided most (57.8 percent) of the surgery done in outpatient hospital settings (see table 21). The predominance of ophthalmologists in this setting is due to cataract surgery which by itself accounted for 6.1 percent of total allowed charges in 1989. Ophthalmologists also accounted for the largest proportion of office surgical charges, 23.5 percent. However, dermatologists and podiatrists also represented significant percentages of office surgical charges, 20.1 and 13.8 percent respectively. In inpatient settings, the traditional surgical specialties—general surgery, orthopedic surgery, urology, thoracic surgery and cardiovascular surgery—accounted for 71 percent of all surgical charges.

RECENT LEGISLATION

Recent legislation, beginning with the enactment of DEFRA in 1984, made significant modifications in the physician payment provisions of Medicare.

DEFRA froze physicians' fees under Medicare for the 15-month period, July 1, 1984, through September 30, 1985. Therefore, the annual updating of customary and prevailing charge screens, otherwise slated for July 1, 1984, did not occur. Subsequent fee screen updates were slated to occur on October 1 of future years beginning in 1985. DEFRA established the concept of participating physicians and specified that the first participation period began October 1, 1984. Participating physicians were subject to the 15-month freeze. They were, however, permitted to increase their billed charges during the freeze period. The law included additional incentives for physicians who agreed to become participating physicians. These included the publication of directories identifying participating physicians and the maintenance by carriers of toll free lines to provide beneficiaries with names of participating physicians.

The law specified that nonparticipating physicians could not increase their billed charges during the 15-month freeze period over the amounts charged for the same services during the April 1, 1984, through June 30, 1984, period. DEFRA required the Secretary to monitor charges of nonparticipating physicians and specified penalties for those who failed to comply with the freeze.

The Temporary Emergency Extension Act of 1985 (P.L. 99-107), as amended, extended the fee freeze provisions through March 14, 1986.

COBRA extended the existing payment provisions through April 1986. In April 1986, physicians were given an opportunity to change their participation status for the 8-month period beginning May 1, 1986. Future update and participation cycles begin on January 1 of each year beginning in 1987. Physicians covered under participation agreements on May 1, 1986, received updates in their customary and prevailing charges. The freeze was extended through December 31, 1986, for nonparticipating physicians. COBRA provided that, beginning January 1, 1987, nonparticipating physicians would be subject to the prevailing charge limits applied to participating physicians during the preceding participation period. (See modification contained in Public Law 99-509, discussed below.)

COBRA also provided for the establishment of an independent Physician Payment Review Commission. The mission and ongoing duties are to make recommendations regarding Medicare physician payments.

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) made a number of changes in the physician payment provisions, as follows:

—Beginning in 1987, all participating and all nonparticipating physicians would receive an increase in their prevailing charge levels, above those in effect for the previous period equal to 3.2 percent.

—The 1 percentage point increase over the MEI, which was allowed for participating physicians for the period beginning May 1, 1986, was built into the base for future calculations.

—The Secretary could not retrospectively revise the calculation of the MEI. The Secretary was required to conduct a study of the MEI to ensure that the index reflects economic changes in an appropriate and equitable manner.

—Nonparticipating physicians were subject to a limit on their actual charges. This was known as the MAAC.

—Where the actual charge for a nonassigned elective surgical procedure exceeds $500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, the excess of the physician's actual charge over the approved charge, and the applicable coinsurance amount.

Public Law 99-509 authorized the Secretary under the inherent reasonableness authority, to establish a payment level for physician services based on criteria other than the actual, customary, and prevailing charge for the service. The law specified criteria and procedures for adjusting payment levels. The Secretary was required to review, by October 1, 1987, the inherent reasonableness of payments for 10 of the most costly procedures paid for under part B. The law also provided for reductions in prevailing charges for cataract surgical procedures.

Public Law 99-509 required the Secretary to study and report to Congress by July 31, 1987, concerning the design and implementation of a prospective payment system for payment under part B for radiology, anesthesiology, and pathology services (RAP services) furnished to hospital inpatients.

COBRA required the Secretary, with the advice of the Physician Payment Review Commission, to develop a relative value scale (RVS) for physician payments. Public Law 99-509 deferred the date the Secretary was required to report on the RVS to July 1, 1989. The potential application date of the RVS was deferred until after December 31, 1989.

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) provided for a number of changes in physician payments. These are as follows:

—The MEI was set to permit faster growth in the prevailing charges of primary care services and for services provided by participating physicians. The differential in prevailing charges between participating and nonparticipating physicians was increased to 5 percent in 1989. The MEI updates in 1988 for primary care services were 3.6 and 3.1 percent for participating and nonparticipating physicians respectively. For other services, the updates were 1.0 and 0.5 percent for participating and nonparticipating physicians. The MEI update in 1988 was delayed from January 1 until April 1.

—The 2.3 percent reduction in payments under Medicare required by the final sequestration order issued under the provisions of the Gramm-Rudman-Hollings Act (as amended) remained in effect through March 31, 1988.

—The prevailing charges of 12 procedures, including cataract and coronary artery bypass surgery, were reduced by 2 percent plus an additional amount up to 15 percent based on a sliding scale; that is, localities with high charges relative to the national average were reduced by a greater amount than areas with low charges.

—The Secretary was required to develop relative value scales (RVS) for radiology, anesthesiology, and pathology services. Certain radiology services provided after January 1, 1989 (services performed by board certified or board-eligible radiologists or by physicians for whom radiology services represented at least 50 percent of their Medicare charges), were to be reimbursed on the basis of an RVS-based fee schedule, set at 97 percent of "budget neutral" fee schedule amounts. Anesthesiology services provided after January 1, 1989, were to be reimbursed based on a nationally defined RVS.

Public Law 100-203 prohibited physicians from billing in excess of the acquisition cost for diagnostic services (other than laboratory tests) that are not performed or supervised by the physician. Physicians are also prohibited from billing patients for laboratory tests that are only covered under Medicare when billed on an assigned basis.

Public Law 100-203 provided for reductions in Medicare payments to physicians to collect past-due obligations arising out of scholarships under the National Health Services Corps Scholarship Program.

The Secretary was required to conduct a variety of studies relating to physician reimbursement and to prepare for the potential implementation of a new reimbursement system based on an RVS.

These studies included the development of uniform definitions of physician services, expansion of the on-going cost-based RVS study to include additional services, and a study of technical issues related to implementation of an RVS-based fee schedule for physician services. The Secretary was also required to study issues related to the volume and intensity of services provided under Part B and to study beneficiary liability for Medicare services, including liability for excess charges on unassigned claims.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989, P.L. 101-239) contained a three part physician payment reform measure which fundamentally restructures the method by which physicians will be reimbursed. The current reasonable charge based reimbursement system will be replaced by a Medicare fee schedule over a 5-year period, beginning in 1992. The new fee schedule is derived from a resource based relative value scale (RBRVS) that sets payments to physicians according to the time, skill and intensity of the service, rather than on historical charges. The fee schedule will be adjusted to account for geographic differences in the cost of practicing medicine and malpractice insurance costs.

In the second part of the reform package, Congress established volume performance standards that are designed to moderate the rate of growth in expenditures for physicians' services. Volume performance standards will be used to advise the Congress in establishing an update to the fee schedule.

The third part of the reform established new limits on beneficiary liability for nonparticipating physicians. The new limits replace the current limits on actual charges of nonparticipating physicians.

In addition, OBRA 1989 placed increased emphasis on research on the quality, effectiveness and outcomes of medical care. In OBRA 1989, Congress created a new agency, the Agency for Health Care Policy and Research, to carry out this mission.

In addition to physician payment reform, Congress enacted other measures concerning physician reimbursement. Most were designed to control federal outlays for physicians' services. These measures include the following:

—Delaying the MEI update until April 1, 1990, granting a 0 percent update for radiology, anesthesia and overvalued services, granting a 2-percent update for all services other than primary care services, and granting a full MEI update (4.2 percent) only for primary care services;

—Reducing prevailing charges up to a maximum of 15 percent for procedures that were identified as being at least 10 percent overvalued by PPRC;

—Reducing the conversion factor for the radiology fee schedule, and granting partial exemptions from the fee schedule for portable x ray services and to specified physicians practicing nuclear medicine;

—Requiring the implementation of a separate pathology fee schedule by January 1, 1991;

—Updating the fee schedule for clinical lab services by 4.7 percent, while also reducing the national cap on fee schedules from 100 percent of the median of the areawide fee schedules to 93 percent of the median;

—Repealing two provisions of existing law that required a nationwide fee schedule for clinical laboratory services and that required high volume physician office labs to comply with the same standards imposed on independent labs. (This was replaced by a provision requiring all laboratories to meet the requirements of the Clinical Laboratory Improvement Amendments.)

The Omnibus Budget Reconciliation Act of 1990 was enacted on November 5, 1990. As part of a 5-year plan to reduce the Federal deficit, Congress reduced projected Medicare outlays by $3.4 billion for fiscal year 1991 and a total of $43.1 billion from fiscal years 1991 through 1995. Reductions in physicians' services outlays accounted for an estimated $945 million in fiscal year 1991, and a total of $9.56 billion from fiscal year 1991 through 1995.

It should be noted that aggregate Medicare outlays (and outlays for physicians' services) are still projected to grow significantly, even with the OBRA 1990 reductions. After the OBRA 1990 reductions have been taken into account, Medicare outlays are still projected to grow from $95.72 billion in fiscal year 1990 to $154.46 billion in fiscal year 1995.

Although OBRA 1990 made reductions in payments for physicians' services, the basic structure of physician payment reform enacted in OBRA 1989 remains intact. The OBRA 1990 reductions in physicians' services can be categorized in three ways: (1) reductions in payments for services considered to be overvalued; (2) reductions in updates for services; and (3) reduction or elimination of payment for services considered either not necessary or duplicative. Included in the first category are: reductions in payments for services identified as overvalued in the past; reductions in services not previously identified as overvalued; reductions of 10 percent in payments for the technical component of magnetic resonance imaging (MRI) and computer axial tomography (CAT) scans; and reductions in payments for anesthesiology, radiology and pathology services, which are generally considered overvalued.

In the second category, OBRA 1990 eliminated the MEI adjustment for all physician services except primary care services; extended the reductions in payments for new physicians until the fifth year of practice; and reduced updates for clinical laboratory services.

In the third category, it eliminated payment for routine interpretations of electrocardiograms and limited payment for the services of assistants-at-surgery to 16 percent, instead of 20 percent, of the surgeon's prevailing charge.

OBRA 1990 also included some measures that will increase Medicare outlays. For example, the conversion factors for certified registered nurse anesthetists (CRNAs) were increased. This provision is intended to increase payment for nonmedically directed CRNAs so that, by 1996, payments to them will equal payments made to anesthesiologists for the same services. Payments to medically directed CRNAs will equal 70 percent of the amount paid to non-medically directed CRNAs.

OBRA 1990 also included a provision designed to alleviate a temporary decrease in total reimbursement for physicians who provide evaluation and management services during 1991. OBRA 1989 imposed new limits on balance billing that would have reduced total reimbursement (Medicare and beneficiary) to physicians providing evaluation and management services in 1991. The new fee schedule, which will be implemented in 1992, is projected to increase payments for these services. Thus, under OBRA 1989, payments to physicians for these services would decrease in 1991 before being increased in 1992. OBRA 1990 addressed this problem by increasing the limit on balance billing for evaluation and management services from 125 percent to 140 percent of the allowed amount for 1991 only.

Section 5. Trade Adjustment Assistance

The trade adjustment assistance (TAA) programs were first established under the Trade Expansion Act of 1962 for the purpose of assisting in the special adjustment problems of workers and firms dislocated as a result of a Federal policy of reducing barriers to foreign trade. As a result of limited eligibility and usage of the programs, criteria and benefits were liberalized under title II of the Trade Act of 1974, Public Law 93-618. The Omnibus Budget Reconciliation Act of 1981 (OBRA), Public Law 97-35, reformed the program for workers as proposed by the Administration. The amendments, particularly in program eligibility and benefits, were intended to reduce program cost significantly and to shift its focus from income compensation for temporary layoffs to a return to work through training and other adjustment measures for the long-term or permanently unemployed. The OBRA also made relatively minor modifications in the program for firms. Most amendments became effective on October 1, 1981. Both programs were extended at that time for 1 year, to terminate on September 30, 1983.

Public Law 98-120 (H.R. 3813 as amended by the Senate), approved on October 12, 1983, extended the worker and firm TAA programs for 2 years until September 30, 1985. Sections 2671-2673 of the Deficit Reduction Act of 1984, Public Law 98-369, included three provisions (sections 3, 6, and 8 of H.R. 3391 as passed by the House on September 15, 1983) which amended the program for workers to increase the availability of worker training allowances and the level of job search and relocation benefits, and amended the program for firms to increase the availability of industrywide technical assistance.

The termination date of the worker and firm TAA programs was further extended under temporary legislation in the first session of the 99th Congress (Public Laws 99-107, 99-155, 99-181, and 99-189) until December 19, 1985. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272 approved April 7, 1986, reauthorized the TAA programs for workers and firms for 6 years retroactively from December 19, 1985, until September 30, 1991, with amendments.

Sections 1421-1430 of Public Law 100-418, the Omnibus Trade and Competitiveness Act of 1988 (OTCA), enacted on August 23, 1988, made significant amendments in the worker TAA program, particularly concerning the eligibility criteria for cash benefits, funding, and administration, further increasing the emphasis on worker training. The amendments also expanded TAA coverage of workers and firms, contingent upon the imposition of an import fee to fund program costs. The OTCA extended TAA program authorization for an additional 2 years until September 30, 1993.

Section 136 of the "Customs and Trade Act of 1990," Public Law 101-382, approved on August 20, 1990, extended the completion and reporting period for the supplemental wage allowance demonstration projects for workers required by the 1988 amendments. No other amendments affecting the TAA programs were enacted in the 101st Congress.

Trade Adjustment Assistance Program for Workers

Trade adjustment assistance for workers under sections 221 through 250 of the Trade Act of 1974, as amended, consists of trade readjustment allowances (TRA), employment services, training and additional TRA allowances while in training, and job search and relocation allowances for certified and otherwise qualified workers. The program is administered by the Employment and Training Administration (ETA) of the Department of Labor through State agencies under cooperative agreements between each State and the Secretary of Labor. ETA processes petitions and issues certifications or denials of petitions by groups of workers for eligibility to apply for TAA. The State agencies act as Federal agents in providing program information, processing applications, determining individual worker eligibility for benefits, issuing payments, and providing reemployment services and training opportunities.

TABLE 1.—NUMBER OF PETITIONS INSTITUTED AND CERTIFIED AND ESTIMATED NUMBER OF WORKERS PETITIONING AND CERTIFIED FOR TRADE ADJUSTMENT ASSISTANCE FROM 1975 THROUGH 1990

Calendar year	Cases instituted		Cases certified		
	Petitions	Estimated workers	Petitions	Percent [1]	Estimated workers
1975	528	210,988	121	50	54,843
1976	1,014	218,544	430	46	143,579
1977	1,289	227,562	411	38	143,716
1978	1,732	171,315	854	42	164,416
1979	2,119	320,714	844	41	221,481
1980	5,347	1,027,277	935	29	585,392
1981	1,134	132,222	260	9	32,992
1982	1,030	170,155	254	20	20,004
1983	959	164,096	482	35	57,094
1984	504	43,812	337	52	15,758
1985	1,392	123,736	491	60	32,098
1986	1,774	166,077	829	39	74,017
1987	1,535	190,881	682	39	86,283
1988	1,948	180,190	658	52	70,486
1989	1,458	142,422	848	41	69,199
1990	1,466	129,370	574	40	62,813
Total	25,229	3,619,361	9,010	36	1,834,171

[1] Estimated percent of petitioning workers certified under completed cases; figures are not precise but indicate the trend.

Certification requirements

A two-step process is involved in the determination of whether an individual worker will receive trade adjustment assistance: (1) certification by the Secretary of Labor of a petitioning group of workers in a particular firm as eligible to apply; and (2) approval by the State agency administering the program of the application for benefits of an individual worker covered by a certification.

The process begins by a group of three or more workers, their union, or authorized representative filing a petition with the ETA for certification of group eligibility. To certify a petitioning group of workers as eligible to apply for adjustment assistance, the Secretary must determine that three conditions are met:

1. A significant number or proportion of the workers in the firm or subdivision of the firm have been or are threatened to be totally or partially laid off;
2. Sales and/or production of the firm or subdivision have decreased absolutely; and
3. Increased imports of articles like or directly competitive with articles produced by the firm or subdivision of the firm have "contributed importantly" to both the layoffs and the decline in sales and/or production.

The OTCA amendments expanded the potential eligibility coverage to include workers in any firm or subdivision of a firm that engages in exploration or drilling for oil or natural gas. In addition to prospective application, this extension applies retroactively to oil and natural gas workers separated from adversely affected employment after September 30, 1985, if they filed a petition by November 18, 1988 (90 days after date of OTCA enactment), were not covered by a prior certification, and could not have been certified eligible prior to the amendments. If an import fee is subsequently imposed (as described below), the OTCA further extends certification eligibility coverage 1 year thereafter to workers with independent firms in any industry that supplies "essential goods or essential services" to firms adversely affected by increased imports.

	Thousands
Total estimated number of workers certified, 1975–90	1,834
Certifications by major industries:	
Automobiles	769
Apparel	230
Steel	172
Footwear	103
Electronics	94
Oil and gas	58
Fabricated metal products	53
Textiles	33

Source: Department of Labor.

The Secretary is required to make the eligibility determination within 60 days after a petition is filed. A certification of eligibility to apply for TAA covers workers who meet the requirements and whose last total or partial separation from the firm or subdivision before applying for benefits occurred within 1 year prior to the filing of the petition.

State agencies must give written notice by mail to each worker to apply for TAA where it is believed the worker is covered by a certification of eligibility and must publish notice of each certification in newspapers of general circulation in areas where certified workers reside. State agencies must also advise each adversely affected worker, at the time that worker applies for UI, of TAA program benefits and the procedures, deadlines, and qualifying requirements for applying, advise each such worker to apply for training before or at the same time that worker applies for TRA benefits, and promptly interview each certified worker and review suitable training opportunities available.

Qualifying requirements for trade readjustment allowances

In order to receive entitlement to payment of a trade readjustment allowance for any week of unemployment, an individual must be an adversely affected worker covered by a certification, file an application with the State agency, and meet the following qualifying requirements:

1. The worker's first qualifying separation from adversely affected employment occurred within the period of the certification applicable to that worker, i.e., on or after the "impact date" in the certification (the date on which total or partial layoffs in the firm or subdivision thereof began or threatened to begin, but never more than 1 year prior to the date of the petition), within 2 years after the date the Secretary of Labor issued the certification covering the worker, and before the termination date (if any) of the certification.
2. The worker was employed during the 52-week period preceding the week of the first qualifying separation at least 26 weeks at wages of $30 or more per week in adversely affected employment with a single firm or subdivision of a firm. As amended in 1986, a week of employment includes the week in which layoff occurs and up to 7 weeks of employer-authorized vacation, sickness, injury, maternity, or military leave, or service as a full-time union representative. Weeks of disability covered by workers' compensation may also count toward the 26-week minimum.
3. The worker was entitled to unemployment insurance (UI), has exhausted all rights to any UI entitlement, including any extended benefits (EB) or Federal supplemental compensation (FSC) (if in existence), and does not have an unexpired waiting period for any UI. Under the program prior to October 1, 1981, TRA benefits were a supplement to State unemployment insurance and were paid concurrently during weeks the worker was eligible for UI. A fundamental change under the 1981 amendments made TRA benefits a continuation of the UI program once UI benefits are exhausted.
4. The worker must not be disqualified for EB with respect to the particular week of unemployment by reason of the work acceptance and job search requirements under section 202(a)(3) of the Federal-State Extended Unemployment Compensation

Act of 1970. All TRA claimants in all States are subject to the provisions of the EB "suitable work" test under that Act (i.e., must accept any offer of suitable work, actively engage in seeking work, and register for work) after the end of their regular UI benefit period as a precondition for receiving any weeks of TRA payments. The EB work test does not apply to workers enrolled or participating in a TAA-approved training program; the test does apply to workers for whom TAA-approved training is certified as not feasible or appropriate.

5. The worker must be enrolled in, or have completed following separation from adversely affected employment within the certification period, a training program approved by the Secretary of Labor in order to receive basic TAA payments, unless the Secretary has determined and submitted a written statement to the individual worker certifying that approval of training is not "feasible or appropriate" (e.g., training is not available that meets the criteria for approval, funding is not available to pay the full training costs, there is a reasonable prospect that the worker will be reemployed by the firm from which separated). No cash benefits may be paid to a worker who, without justifiable cause, has failed to begin participation or has ceased participation in an approved training program until the worker begins or resumes participation, or to a worker whose waiver of participation in training is revoked in writing by the Secretary. This training requirement to encourage and enable workers to obtain early reemployment became effective under the OTCA amendments as of November 21, 1988; this 1988 amendment replaced a 1986 amendment that instituted a job search requirement as a condition for receiving cash benefits.

Cash benefit levels and duration

A worker is entitled to TRA payments for weeks of unemployment beginning the later of (a) the first week beginning more than 60 days after the filing date of the petition that resulted in the certification under which the worker is covered (i.e., weeks following the statutory deadline for certification), or (b) the first week after the worker's first total qualifying separation. As a result of the 1981 amendments, workers can no longer receive retroactive cash benefits for weeks of unemployment occurring up to 1 year prior to the filing of the petition.

The TRA cash benefit amount payable to a worker for a week of total unemployment is equal to, and a continuation of, the most recent weekly benefit amount of unemployment insurance payable to that worker preceding that worker's first exhaustion of UI following the worker's first total qualifying separation under the certification, reduced by any Federal training allowance and disqualifying income deductible under UI law.

The maximum amount of *basic* TRA benefits payable to a worker for the period covered by any certification is 52 times the TRA payable for a week of total unemployment minus the total amount of UI benefits to which the worker was entitled in the benefit period in which the first qualifying separation occurred (e.g., a worker receiving 39 weeks of UI regular and extended benefits could receive a maximum 13 weeks of basic TRA benefits). UI and TRA payments combined are limited to a maximum 52 weeks in all cases involving extended compensation benefits (i.e., a worker who received 52 or more weeks of unemployment benefits would not be entitled to basic TRA). TRA benefits are not payable to workers participating in on-the-job training.

TRA benefits prior to October 1, 1981, were a uniform national standard of 70 percent of the worker's former gross weekly wage not to exceed the average weekly manufacturing wage, reduced by the amount of the worker's unemployment compensation entitlement, 50 percent of any part-time earnings, and certain Federal training allowances. The purpose of shifting cash benefits to State standards and other changes under the OBRA, effective as of October 1, 1981, was to reduce program costs, to remove reemployment disincentives associated with the previous high net wage replacement, and to reduce the inequity in benefit amounts payable to import-impacted workers versus workers laid off for other reasons.

The 1988 amendments essentially restored the moveable 2-year eligibility period for collecting basic TRA in effect prior to the 1981 amendments (i.e., restored eligibility to the most recent rather than from the first qualifying separation). The eligibility period for collecting basic TRA is the 104-week period that immediately follows the week in which a total qualifying separation occurs. If the worker has a subsequent total qualifying separation under the same certification, the eligibility period for basic TRA moves from the prior eligibility period to 104 weeks after the week in which the subsequent total qualifying separation occurs. This amendment also applies retroactively to workers who experienced a total qualifying separation in the period beginning on August 13, 1981 (date of enactment of the 1981 amendments), and ending on April 7, 1986 (date of enactment of the 1986 amendments), if the worker is enrolled in an approved training program, has not failed or ceased to participate in the program without justifiable cause, and has been unemployed continuously since the total separation (aside from seasonal employment, odd jobs, or part-time temporary employment).

A worker may receive up to 26 *additional* weeks of TRA benefits after collecting basic benefits (up to a total maximum of 78 weeks) if that worker is participating in approved training, in order to assist in completing such training. To receive the additional benefits, the worker must apply for the training program within 210 days after certification or first qualifying separation, whichever date is later. Additional benefits may be paid only during the 26-week period that follows the last week of entitlement to basic TRA, or that begins with the first week of training if the training begins after the exhaustion of basic TRA.

As provided in the 1988 amendments, a worker participating in approved training will continue to receive basic and additional TRA payments during breaks in such training if the break does not exceed 14 days, if the worker was participating in the training before the beginning of the break, resumes participation in the training after the break ends, and the break is provided for in the training schedule. Prior to the OTCA amendments, the worker had to be actually engaged in training in a particular week to be entitled to additional TRA for that week. Weeks when TRA is not payable because of this break provision still count against the eligibility periods for both basic and additional TRA.

TABLE 2.—TOTAL OUTLAYS FOR TRADE READJUSTMENT ALLOWANCES, NUMBER OF RECIPIENTS, AVERAGE WEEKLY PAYMENTS AND DURATION, FISCAL YEARS 1976 THROUGH 1996

Fiscal year	Total outlays (millions)	Total number of recipients (thousands)	Average weekly payment per recipient	Average duration [1] (weeks)
1975 (4th quarter)	$71	47	$58	26
1976 [2]	79	62	47	27
1977	148	111	57	23
1978	257	156	68	24
1979	256	132	70	27
1980	1,622	532	126	24
1981	1,440	281	140	36
1982	103	30	119	28
1983	37	30	120	10
1984	35	16	139	16
1985	43	20	133	15
1986	116	40	144	19
1987	208	55	155	24
1988	186	47	165	21
1989	125	24	[3] 175	23
1990 [3]	92	19	162	22
1991 [4]	157	25	197	26
1992 [4]	155	24	204	26
1993 [4]	149	23	211	25
1994 [4]	144	22	219	24
1995 [4]	138	20	227	23
1996 [4]	132	19	235	22

[1] These figures relate to nontraining only.

[2] Fiscal year 1976 is the first full year of experience under the program as amended by the Trade Act of 1974.

[3] Estimated by the Department of Labor.

[4] Fiscal years 1991 through 1996 numbers are CBO January 1991 baseline estimates.

Note: The above figures relate only to trade readjustment allowances; administrative expenses and outlays for employment services, training, and job search and relocation allowances are not included.

Source: Department of Labor.

Training and other employment services, job search and relocation allowances

Training and other employment services and job search and relocation allowances are available through State agencies to certified workers whether or not they have exhausted UI benefits and become eligible for TRA payments.

Employment services consist of counseling, vocational testing, job search and placement, and other supportive services, provided for under any other Federal law.

Training, preferably on-the-job, shall be approved for a worker if the following six conditions are met:

(1) There is no suitable employment available;

(2) The worker would benefit from appropriate training;

(3) There is a reasonable expectation of employment following training completion;

(4) Approved training is reasonably available from government agencies or private sources;

(5) The worker is qualified to undertake and complete such training; and

(6) Such training is suitable for the worker and available at a reasonable cost.

If training is approved, the worker is entitled to payment of the costs from the Secretary directly or through a voucher system, unless they have been paid or are reimbursable under another Federal law. On-the-job training costs are payable only if such training is not at the expense of currently employed workers. The 1988 amendments added remedial education as a separate and distinct approvable training program, whereas previously it was approvable only as part of a broader training program that also included skills training.

The OTCA amendments converted training from an entitlement to the extent appropriated funds were available, as provided in the 1986 amendments, to an entitlement without regard to the availability of funds to pay the training costs. Pursuant to the OTCA amendments, effective on August 23, 1988, approved training is an entitlement in any case where the six criteria for approval are reasonably met, up to an $80 million statutory ceiling on annual fiscal year training costs (including job search and relocation allowances and subsistence payments) payable from TAA funds. Up to this limit, workers are entitled to have the costs of approved training paid on their behalf. If the Secretary foresees that the $80 million ceiling will be exceeded in any fiscal year, the Secretary can decide how remaining TAA funds shall be apportioned among the States for the balance of that year.

As a result of the OTCA amendments, costs of approved TAA training may be paid solely from TAA funds, solely from other Federal or State programs or private funds, or from a mix of TAA and public or private funds, except if the worker in the case of a nongovernmental program would be required to reimburse any portion of the costs from TAA funds. Duplicate payment of training costs is prohibited, and workers are not entitled to payment of training costs from TAA funds to the extent these costs are paid or shared from other sources. Training may still be approved if the fiscal year TAA funding entitlement limit is reached if the training costs are paid from outside sources.

Supplemental assistance is available to defray reasonable transportation and subsistence expenses for separate maintenance when training is not within the worker's commuting distance, equal to the lesser of actual per diem expenses or 50 percent of the prevailing Federal per diem rate for subsistence and prevailing mileage rates under Federal regulations for travel expenses.

Job search allowances are available to certified workers who cannot obtain suitable employment within their commuting area, are totally laid off, and who apply within 1 year after certification or last total layoff, whichever is later, or within 6 months after concluding training. As amended in 1981 and 1984, the allowance for reimbursement is equal to 90 percent of necessary job search expenses, based on the same increased supplemental assistance rates described above, up to a maximum amount of $800. The 1986 amendments require the Secretary of Labor to reimburse workers for necessary expenses incurred to participate in an approved job search program.

TABLE 3.—TRAINING, JOB SEARCH, AND RELOCATION ALLOWANCES: TOTAL NUMBER OF WORKERS AND OUTLAYS, FISCAL YEARS 1976 THROUGH 1990

Fiscal year	Total number			Total outlays (millions) [1]
	Entered training	Job searches	Relocations	
1975 (4th quarter)	463	158	44	
1976	823	23	26	$2.7
1977	4,213	277	191	4.0
1978	8,337	1,072	631	12.8
1979	4,458	1,181	855	13.5
1980	[2] 9,475	931	629	6.0
1981	[2] 20,386	1,491	2,011	4.2
1982	5,844	697	662	19.4
1983	11,299	696	3,269	36.0
1984	6,821	799	2,220	19.0
1985	7,424	916	1,692	30.2
1986	9,400	1,053	1,844	29.9
1987	22,887	1,705	1,539	49.9
1988	9,538	1,156	1,347	54.4
1989	15,232	863	989	62.7
1990 [3]	18,400	560	1,200	57.6
Total [3]	150,875	12,961	19,266	402.2

[1] Excludes administrative costs.

[2] Of total workers entering training, 5,640 (59 percent) in 1980 and 18,940 (94 percent) in 1981 self-financed their training costs.

[3] Estimated.

Source: Department of Labor.

Relocation allowances are available to certified workers totally laid off at time of relocation who have been able to obtain an offer of or actual suitable employment only outside their commuting area, who apply within 14 months after certification or last total layoff, whichever is later, or within 6 months after concluding training, and whose relocation takes place within 6 months after application or completion of training. As amended in 1981 and 1984, the allowance is equal to 90 percent of reasonable and necessary expenses for transporting the worker, family, and household effects, based on the same increased supplemental assistance rates described above, plus a lump sum payment of three times the worker's average weekly wage up to a maximum amount of $800.

Funding

Federal funds, as an entitlement from general revenues under the Federal Unemployment Benefit Account (FUBA) in the Department of Labor, cover the portion of the worker's total entitlement represented by the continuation of UI benefit levels in the form of TRA payments, plus the salaries and expenses for ETA personnel administering the program. Funds made available under grants to States defray expenses of any employment services. Funding for training, job search and relocation allowances, and related expenses is an annual appropriated entitlement under the Training and Employment Services account of the Department of Labor.

For fiscal year 1991, $228 million is appropriated for trade readjustment allowance benefits, training and job search and relocation allowances, and related administrative expenses. Under the CBO January 1991 baseline, annual outlays for training, job search, and relocation allowances are estimated to be $55 million in fiscal year 1991, $68 million in 1992, $71 million in 1993, $71 million in fiscal year 1994, $70 million in fiscal year 1995, and $68 million in fiscal year 1996.

The States are reimbursed from Treasury general revenues for benefit payments and other costs incurred under the program. A penalty under section 239 of the Trade Act of 1974 provides for reduction by 15 percent of the credits for State unemployment taxes which employers are allowed against their liability for Federal unemployment taxes if a State has not entered into, or has not fulfilled its commitments, under a cooperative agreement.

TRADE ADJUSTMENT ASSISTANCE PROGRAM FOR FIRMS

Sections 251–264 of the Trade Act of 1974, as amended, contain the procedures, eligibility requirements, benefits and their terms and conditions, and administrative provisions of the trade adjustment assistance program for firms adversely impacted by increased import competition. The program is administered within the Department of Commerce by the Economic Development Administration. Amendments in 1986 under the COBRA eliminated financial assistance (direct loan or loan guarantee) benefits, increased government participation in technical assistance, and expanded the criteria for firm certification.

Program benefits consist exclusively of technical assistance for petitioning firms which qualify under a two-step procedure: (1) certification by the Secretary of Commerce that the petitioning firm is eligible to apply, and (2) approval by the Secretary of Commerce of the application by a certified firm for benefits, including the firm's proposal for economic adjustment.

To certify a firm as eligible to apply for adjustment assistance, the Secretary must determine that three conditions are met:

1. A significant number or proportion of the workers in the firm have been, or are threatened to be, totally or partially laid off;
2. Sales and/or production of the firm have decreased absolutely, or sales and/or production that accounted for at least 25 percent of total production or sales of the firm during the 12

months preceding the most recent 12-month period for which data are available have decreased absolutely; and

3. Increased imports of articles like or directly competitive with articles produced by the firm have "contributed importantly" to both the layoffs and the decline in sales and/or production.

The 1988 amendments expanded potential eligibility coverage of the program to include firms that engage in exploration or drilling for oil or natural gas. Unlike the worker program, this extension applies only prospectively after August 23, 1988.

A certified firm may file an application with the Secretary of Commerce for trade adjustment assistance benefits at any time within 2 years after the date of the certification of eligibility. The application must include a proposal by the firm for its economic adjustment. The Secretary may furnish technical assistance to the firm in preparing its petition for certification and/or in developing a viable economic adjustment proposal.

The Secretary approves the firm's application for assistance only if he determines that its adjustment proposal (1) is reasonably calculated to make a material contribution to the economic adjustment of the firm; (2) gives adequate consideration to the interests of the workers in the firm; and (3) demonstrates that the firm will make all reasonable efforts to use its own resources for economic development.

Benefits

Technical assistance may be given to implement the firm's economic adjustment proposal in addition to, or in lieu of, precertification assistance or assistance in developing the proposal. It may be furnished through existing government agencies or through private individuals, firms, and institutions (including private consulting services), or by grants to intermediary organizations, including regional Trade Adjustment Assistance Centers. As amended by the COBRA, the Federal Government may bear the full cost of technical assistance to a firm in preparing its petition for certification. However, the Federal share cannot exceed 75 percent of the cost of assistance furnished through private individuals, firms, or institutions for developing or implementing an economic adjustment proposal. Grants may be made to intermediate organizations to defray up to 100 percent of their administrative expenses in providing technical assistance.

As amended in 1984, the Secretary of Commerce also may provide technical assistance of up to $10 million annually per industry to establish industrywide programs for new product or process development, export development, or other uses consistent with adjustment assistance objectives. The assistance may be furnished through existing agencies, private individuals, firms, universities, and institutions, and by grants, contracts, or cooperative agreements to associations, unions, or other nonprofit organizations of industries in which a substantial number of firms or workers have been certified.

Funding

Funds to cover all costs of the program are subject to annual appropriations to the Economic Development Administration of the Department of Commerce from general revenues. For fiscal year 1991, a total of $12.950 million has been appropriated to the program.

MOST RECENT MAJOR LEGISLATIVE CHANGES

Sections 1421-1430 of the Omnibus Trade and Competitiveness Act of 1988 made a number of significant amendments to the TAA programs for workers and firms under Chapter 2 of Title II of the Trade Act of 1974 and extended the programs for 2 years until September 30, 1993. Most of the amendments took effect on date of enactment, August 23, 1988. The major provisions were as follows:

Eligibility coverage

Program eligibility was extended to workers and firms that engage in exploration or drilling for oil or natural gas.

Program eligibility was extended to otherwise qualified secondary workers and firms in any industry that supplies "essential goods or essential services" to firms directly impacted by increased imports, conditioned upon imposition of an import fee within 2 years and effective 1 year thereafter.

TRA benefits

The most recent, rather than the first, separation from employment is to be used for determining the beginning of a worker's 104-week eligibility period to collect TRA benefits; this change was also applied retroactively to workers laid off between August 13, 1981, and April 7, 1986, if they have been continuously unemployed since layoff and are enrolled in training.

The Department of Labor was required to establish a demonstration project to evaluate supplemental wage allowances as an option for workers qualified for TRA who take new full-time employment paying less than their previous job, and report the results to Congress. As a result of an extension enacted in 1990, this report is due by August 23, 1994.

Training

Participation in training was required as a condition for an individual worker to receive basic weekly cash benefits (TRA), unless the requirement is waived because training is not feasible or appropriate.

TRA benefits were made payable to workers in training during scheduled program breaks of no more than 14 days.

Approved worker training was made an appropriated entitlement from general revenues, "capped" at $80 million per fiscal year; training must be approved and the worker is entitled to payment of the cost if six statutory criteria are met, including a new sixth criterion requiring that training be appropriate for suitable employment and available at a reasonable cost. If an import fee were imposed, the appropriated entitlement would be funded from that fee 1 year thereafter and the "cap" raised to $120 million to include the cost of training secondary workers.

Import fee

The President was required to undertake negotiations in the General Agreement on Tariffs and Trade and with parties to bilateral free trade areas to permit imposition by countries of a small uniform duty on all imports (with limited exceptions) to fund programs which directly assist adjustment to import competition, not to exceed program costs or a maximum 0.15 percent ad valorem. If negotiations were not successful within 2 years (i.e., by August 23, 1990), the President was required to impose a fee unless he determined and reported to Congress that imposition was not in the national economic interest; the fee would be imposed upon enactment of a joint disapproval resolution passed by Congress within 90 days under expedited procedures.

A trust fund consisting of revenues equivalent to amounts attributable to the import fee would be established if and when an import fee was imposed to finance the worker and firm TAA programs. The amount equivalent to the maximum level of the import fee of 0.15 percent ad valorem would constitute an overall ceiling on total program expenditures, as well as a "cap" on the total benefit entitlement for workers. Within that overall "cap", a second "cap" of $120 million would apply to worker training entitlement costs. Funding for the worker TAA program would continue to be an appropriated entitlement; firm TAA would continue to be a discretionary program subject to appropriations.

On August 23, 1990, the President notified the Congress that negotiations had not gained the acceptance by any foreign trading parties for an import fee and that unilateral imposition of a fee would not be in the U.S. national economic interest. No resolutions were introduced in the House or Senate to disapprove the President's determination.

Program administration

Training costs may be paid totally or partially from other Federal or State programs or from private sources.

State agency responsibilities for providing notice and program benefit information to workers were expanded; coordination was provided at the State level in the administration of training and other employment services between worker TAA and the dislocated worker program under the Job Training Partnership Act.

Section 6. Unemployment Compensation

OVERVIEW

The Social Security Act of 1935 (Public Law 74-271) created the Federal-State unemployment compensation (UC) system. It has two main objectives: (1) to provide temporary and partial wage replacement to involuntarily unemployed workers who were recently employed; and (2) to help stabilize the economy during recessions. The U.S. Department of Labor oversees the system, but each State administers its own program. Because Federal law defines the District of Columbia, Puerto Rico, and the Virgin Islands as "States" for the purposes of unemployment compensation, there are 53 State programs.

The Federal Unemployment Tax Act of 1939 (Public Law 76-379) and titles III, IX, and XII of the Social Security Act form the framework of the system. The Federal Unemployment Tax Act (FUTA) currently imposes a 6.2 percent gross tax rate on the first $7,000 paid annually by covered employers to each employee. Employers in States with programs approved by the Federal Government and with no delinquent Federal loans may credit 5.4 percentage points against the 6.2 percent tax rate, making the minimum, net Federal unemployment tax rate 0.8 percent. This Federal revenue finances administration of the system, half of the Federal-State extended benefits program, and a Federal account for State loans. In theory, the States are supposed to use the revenue turned back to them by the 5.4 percent credit to finance their regular State programs and half of the Federal-State extended benefits program.

In 1976 Congress passed a temporary surtax of 0.2 percent of taxable wages to be added to the permanent FUTA tax rate (Public Law 94-566). Thus, the current 0.8 percent FUTA tax rate has two components: a permanent tax rate of 0.6 percent and a temporary surtax rate of 0.2 percent. Under the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the 0.2 percent surtax was extended for 3 years through 1990. The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) extended it again through 1995.

TABLE 1.—UNEMPLOYMENT COMPENSATION PROGRAM STATISTICS

	Fiscal year—											
	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991 (estimated)	1992 (projected) [1]
Total civilian unemployment rate (percent)	7.3	9.1	10.1	7.8	7.2	7.0	6.4	5.6	5.3	5.4	6.6	6.7
Insured unemployment rate (percent) [2]	3.5	4.4	4.3	2.9	2.9	2.8	2.5	2.2	2.1	2.3	3.1	3.0
Coverage (millions of individuals)	88.2	86.8	86.3	89.9	93.0	95.7	97.9	100.6	103.9	105.6	104.9	106.2
Average weekly benefit amount (current dollars)	102	114	120	119	122	129	135	140	145	154	162	169
In 1989 dollars [3]	142	148	149	142	140	145	147	147	145	147	148	148
State unemployment compensation:												
Beneficiaries (millions of individuals)	8.8	11.4	9.9	7.6	8.4	8.4	7.5	6.8	7.0	8.1	10.7	10.2
Regular benefit exhaustions (millions of individuals)	3.2	3.7	4.6	2.8	2.6	2.6	2.5	1.9	1.9	2.2	3.0	3.3
Regular benefits paid (billions of dollars)	13.46	19.34	20.84	13.3	14.3	15.6	15.0	13.2	13.5	16.8	24.3	24.7
Extended benefits (State share: billions of dollars)	1.06	.93	1.21	.03	.03	.05	.04	.01	(6)	.03	.14	.03
State tax collections (billions of dollars)	12.37	12.77	14.43	19.04	20.01	18.8	19.1	18.3	17.3	16.0	15.6	17.2
State trust fund impact (income-outlays: billions of dollars) [4]	−2.15	−7.50	−7.62	+5.70	+5.65	+3.17	+4.11	+5.09	3.80	−.88	−8.87	−7.52
Federal unemployment compensation accounts:												
Federal tax collections (billions of dollars) [5]	3.26	3.18	3.58	5.02	4.44	4.08	5.08	5.50	4.45	5.36	5.30	5.43
Outlays: Federal extended benefits share plus Federal supplemental benefits (billions of dollars)	1.06	.97	6.80	3.01	1.27	.05	.04	.04	(7)	.03	.14	.03
State administrative costs (billions of dollars):												
Unemployment Insurance Service	1.32	1.42	1.70	1.58	1.58	1.57	1.56	1.61	1.71	1.80	1.98	2.26
Employment Service [6]	.73	.68	.72	.76	.92	.93	.90	.95	1.00	1.00	1.04	1.02
Total administrative costs	2.05	2.10	2.42	2.31	2.50	2.50	2.46	2.56	2.71	2.80	3.02	3.28

[1] Based on President's 1992 budget. [2] The average number of workers claiming State unemployment compensation benefits as a percent of all workers covered. [3] Adjusted using CPI–X1. [4] Excludes interest earned. [5] Net of reduced credits. [6] Includes Bureau of Labor Statistics and Veterans' Employment Service. [7] Less than $5 million.

Sources: Office of Research, Legislation and Program Policies/ETA/UIS/DOL, Division of Actuarial Services, and U.S. Budget Appendixes.

FINANCING

The Federal Unemployment Tax Act (FUTA) generally determines covered employment. FUTA also imposes certain requirements on the State programs, but the States generally determine individual qualification requirements, disqualification provisions, eligibility, weekly benefit amounts, potential weeks of benefits, and the State tax structure used to finance all of the regular State benefits and half of the extended benefits.

The Social Security Act provides for the administrative framework. Title III authorizes Federal grants to the States for administration of the State UC laws. Title IX authorizes the various components of the Federal Unemployment Trust Fund. Title XII authorizes advances or loans to insolvent State UC programs.

THE UNEMPLOYMENT TRUST FUND

The Federal unified budget accounts for all Federal-State UC outlays and taxes in the Federal Unemployment Trust Fund. The Unemployment Trust Fund has 59 accounts. The accounts consist of 53 State UC program accounts, the Railroad Unemployment Insurance Account, Railroad Administration Account, and four Federal accounts. (See part 2, section 3.)

The four Federal accounts in the trust fund are: (1) the Employment Security Administration Account (ESAA), which funds administration; (2) the Extended Unemployment Compensation Account (EUCA), which funds the Federal half of the Federal-State extended benefits program; (3) the Federal Unemployment Account (FUA), which funds loans to insolvent State UC programs; and (4) the Federal Employee Compensation Account (FECA), which funds benefits for Federal civilian and military personnel authorized under 5 U.S.C. 85. Federal unemployment taxes finance the ESAA, EUCA, and FUA, but general revenues finance the FECA. Present law authorizes interest-bearing loans to ESAA, EUCA, and FUA from the general fund.

Financial Condition of the Unemployment Trust Fund

Federal Accounts.—The flow of funds into the Federal accounts in fiscal year 1991 is about $9 billion away from breaching the ceilings of the three accounts and overflowing to the State accounts. The Employment Security Administration Account (ESAA) has reached its ceiling of $1.2 billion; the Extended Unemployment Compensation Account (EUCA) has reached its ceiling of $7.6 billion, but the Federal Unemployment Account (FUA) falls short of its ceiling by $9.2 billion. The ceilings in EUCA and FUA accounts were set by the Omnibus Budget Reconciliation Act of 1987 to reflect the amount of funds that would be needed to cover increased outlays resulting from a future recession.

Under the administration's fiscal year 1992 budget assumptions, the Federal accounts will continue to fall short of their ceilings throughout the 5-year projection period. By the end of fiscal year 1996, FUA still would be short by about $4.5 billion.

State Accounts.—The State accounts have recovered substantially from the financial problems that began in the 1970's and continued through most of the 1980's. Table 2 shows that the State accounts currently hold almost $40 billion, which represents a remarkable level given the negative balance of nearly $3 billion in 1982.

Although the balances in the State accounts appear comparable in real dollars to those in 1970 before the serious financial problems began for most States, State reserve ratios paint a different picture. Table 2 shows State reserve ratios (trust fund balances divided by total wages paid in the respective States during the year). The third column from the right margin shows that State balances are only at 66 percent of their reserve status in 1970. This suggests that States will be at risk of financial problems if the U.S. economy experiences a major recession.

For the third quarter of 1990, the second-to-last column of table 2 shows for each State their "High-Cost Multiples," the ratio of their reserve ratios to their highest cost rates. Their highest cost rates are determined by choosing the highest ratio of costs to total covered wages paid in a prior year. States with high-cost multiples of at least 1.0 have reserves that could withstand a recession as bad as the worst one they have experienced previously. In the past, States with high-cost multiples below 1.0 have been at significant risk of insolvency during recessions.

Twenty-seven States had high-cost multiples below 1.0. Eighteen States had high-cost multiples below 0.8, and eight States had high-cost multiples below 0.5. Based on this measure, those States in the worst financial shape were Connecticut, Massachusetts, Ohio, Michigan, the District of Columbia, Arkansas, West Virginia, and Missouri.

TABLE 2.—FINANCIAL CONDITION OF STATE UNEMPLOYMENT COMPENSATION PROGRAMS

States	Net reserves (end of calendar year) [In millions of dollars]					Reserve ratios [Percent]					Ratio of 1990/1970	High-cost multiple [1]	Rank
	1970	1975	1979	1982	1990 [1]	1970	1975	1979	1982	1990 [1]			
Total	11,903	3,070	8,583	(2,645)	39,680	3.11	0.53	0.91	−0.24	2.04	66		
Alabama	130	(2)	118	9	648	2.96	0	.98	.06	2.69	91	1.24	17
Alaska	35	75	65	134	217	5.51	3.07	2.78	2.94	4.75	86	1.10	22
Arizona	119	67	226	215	507	4.25	1.35	2.36	1.66	2.11	50	.85	33
Arkansas	49	2	24	(77)	141	2.26	.04	.37	0	1.14	50	.43	48
California	1,219	546	2,738	2,708	5,716	2.91	.88	2.51	1.83	2.15	74	.92	30
Colorado	91	47	137	(4)	295	2.54	.70	1.11	0	1.15	45	.91	31
Connecticut	252	(232)	(267)	(252)	127	0.08	0	0	0	.34	425	.10	53
Delaware	22	0	(30)	(35)	231	1.72	0	0	0	3.52	205	1.30	14
District of Columbia	74	(3)	(44)	(57)	78	3.22	0	0	0	.76	24	.41	49
Florida	268	80	665	865	2,066	2.60	.42	2.13	1.89	2.39	92	1.30	14
Georgia	340	268	447	397	1,093	4,74	2.28	2.28	1.49	2.14	45	1.01	26
Hawaii	44	5	79	108	393	2.90	.23	2.24	2.43	4.16	143	1.57	7
Idaho	46	54	93	29	243	5.16	3.21	3.20	.85	4.68	91	1.47	11
Illinois	401	(31)	(460)	(2,069)	1,510	1.55	0	0	0	1.47	95	.55	45
Indiana	326	198	418	63	870	3.13	1.31	1.69	.23	2.09	67	1.17	21
Iowa	125	63	155	(63)	567	3.19	.96	1.45	0	3.40	107	1.30	14
Kansas	84	135	238	142	539	3.00	2.65	2.75	1.29	2.99	100	1.52	9
Kentucky	175	137	159	(121)	427	4.21	1.95	1.36	0	2.04	48	.74	38
Louisiana	146	141	238	(102)	435	2.91	1.58	1.51	0	1.86	64	.60	43

TABLE 2.—FINANCIAL CONDITION OF STATE UNEMPLOYMENT COMPENSATION PROGRAMS—Continued

States	Net reserves (end of calendar year) [In millions of dollars]					Reserve ratios [Percent]					Ratio of 1990/1970	High-cost multiple [1]	Rank
	1970	1975	1979	1982	1990 [1]	1970	1975	1979	1982	1990 [1]			
Maine	39	2	0	(4)	194	2.86	0	0	0	2.49	87	.88	32
Maryland	213	29	273	220	563	3.26	.29	1.83	1.11	1.52	47	.69	39
Massachusetts	378	(99)	132	436	549	3.04	0	0	1.23	.87	29	.27	52
Michigan	491	(286)	112	(2,186)	1,033	2.49	0	.25	0	1.34	54	.36	50
Minnesota	119	(35)	70	(288)	401	1.76	0	.41	0	1.11	63	.57	44
Mississippi	85	90	231	257	391	3.87	2.25	3.47	3.12	3.28	85	1.66	4
Missouri	264	95	296	(64)	338	3.03	.75	1.47	0	.89	29	.45	46
Montana	26	8	16	9	89	3.33	.57	0	.27	2.09	63	.69	39
Nebraska	55	29	81	72	142	2.87	.84	1.58	1.14	1.53	53	1.02	25
Nevada	39	5	95	122	352	3.20	.22	2.31	2.02	3.26	102	1.19	20
New Hampshire	55	29	82	75	187	4.62	1.56	2.42	1.60	2.05	44	.82	35
New Jersey	448	(348)	(507)	(423)	2,921	2.76	0	0	0	3.65	132	1.10	22
New Mexico	40	33	80	101	198	3.45	1.61	2.14	1.98	2.71	79	1.65	5
New York	1,693	574	403	819	2,808	3.76	1.02	.51	.78	1.65	44	.66	41
North Carolina	414	342	564	400	1,530	5.22	2.71	2.71	1.52	3.18	61	1.23	18
North Dakota	13	22	21	11	51	2.53	1.94	1.13	.46	1.79	71	.76	37
Ohio	693	294	513	(1,658)	921	3.01	.91	1.02	0	1.10	37	.36	50
Oklahoma	55	27	177	108	391	1.69	.46	1.56	.62	2.20	130	1.61	6
Oregon	122	24	320	161	959	3.39	.40	3.00	1.37	5.03	148	1.57	7
Pennsylvania	852	(86)	(1,091)	(2,145)	1,802	3.53	0	0	0	2.05	58	.61	42

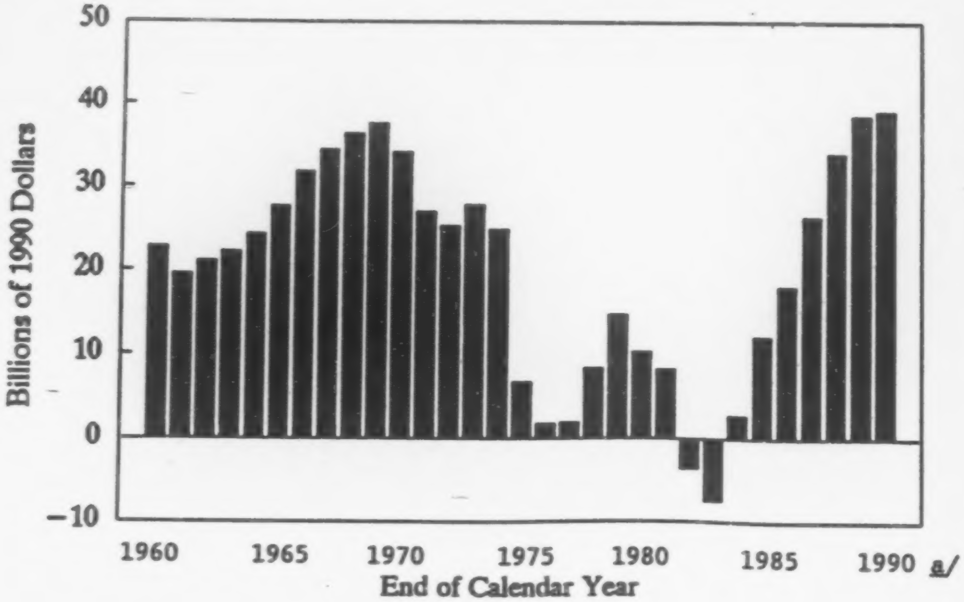
Puerto Rico	85	(26)	(33)	(47)	666	4.90	0	0	0	9.30	190	2.21	2
Rhode Island	75	(41)	(96)	(76)	276	4.34	0	0	0	3.63	84	.83	34
South Carolina	166	95	195	50	494	4.61	1.61	1.96	.40	2.23	48	.77	36
South Dakota	8	20	16	9	48	3.81	1.96	.95	.43	1.58	41	1.52	9
Tennessee	212	200	264	15	696	3.57	1.95	1.63	.08	2.04	57	.94	29
Texas	337	231	396	142	1,303	1.90	.71	.65	0	1.08	57	.95	28
Utah	51	32	67	10	280	3.55	1.22	1.43	.16	2.91	82	1.44	12
Vermont	26	(25)	(21)	(27)	211	3.72	0	0	0	5.48	147	1.69	3
Virginia	218	122	103	14	747	3.41	1.08	.56	.06	1.57	46	1.20	19
Virgin Islands	NA	NA	(7)	46	35	NA	NA	0	0	7.23	NA	3.17	1
Washington	226	(67)	297	(3)	1,579	3.73	0	1.66	.70	4.61	124	1.09	24
West Virginia	108	78	39	150	160	4.07	1.70	.56	0	1.77	43	.44	47
Wisconsin	322	121	465	(144)	1,186	4.29	.99	2.37	0	3.38	79	1.31	13
Wyoming	19	31	69	(413)	76	4.29	3.02	3.15	1.44	2.98	69	.98	27

---

[1] Data are for the third quarter of calendar year 1990.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, UI Data Summary, 3rd quarter, CY 90, Dec. 1990. U.S. Department of Labor Employment and Training Administration on Unemployment Insurance Financial Handbook Data.

CHART 1. REAL NET BALANCE IN STATE ACCOUNTS IN THE UNEMPLOYMENT TRUST FUND, 1960–1990



a. Data for 1990 are at the end of the fiscal year.

Source: Congressional Budget Office, based on Department of Labor, "Unemployment Insurance Financial Data," and unpublished data.

TABLE 3.—END-OF-YEAR BALANCES IN UNEMPLOYMENT TRUST FUND ACCOUNTS FOR SELECTED FISCAL YEARS

[In millions of dollars]

Account	1970	1975	1979	1982	1990
Employment security administration	65	365	572	545	1,076
Extended unemployment compensation	0	116	764	483	7,192
Federal unemployment (reserve for State loans)	575	9	567	599	3,173
Federal employee compensation	(¹)	(¹)	(¹)	24	106
State unemployment compensation [2]	12,409	6,145	8,272	720	39,077
Total: Nominal dollars	13,049	6,635	10,175	2,371	50,624
Total: Real dollars [3]	41,705	15,767	18,177	3,235	50,624

[1] There was no separate account for Federal employee compensation for this year.

[2] Figures are net of loans from Federal funds.

[3] Real dollars are obtained using CPI–X1.

Source: U.S. Department of Labor, Unemployment Insurance Service, Division of Actuarial Services.

Table 3 summaries the year end balances in the unemployment trust fund accounts for selected years. At the end of fiscal year 1990, the five accounts combined had a total balance of $50.6 billion. In real terms this represents a growth of 21 percent since 1970. Although in real dollars the aggregate amount in the State accounts is about the same as was reached in 1970, this does not suggest that each State's reserves are adequate. Real balances do not take into account the 53-percent increase in the labor force over this time period. A better measure is the ratio of the 1990 to 1970 reserve ratios in table 2, which shows that aggregate reserves in 1990 are only about two-thirds of their level in 1970.

The Federal unemployment tax

Total unemployment taxes on employers for a full-time, full-year worker earning the average wage in covered employment in 1989 is estimated to have averaged $234 or 11 cents per hour. The Federal portion is $56 or 3 cents per hour and the average State portion is $178 or 9 cents per hour. Employer taxes vary substantially, however, depending on the State taxable wage base, State tax schedules, and Federal credits.

The Federal Unemployment Tax Act (FUTA) currently imposes a minimum, net Federal payroll tax on employers of 0.8 percent on the first $7,000 paid annually to each employee. The gross FUTA tax rate is 6.2 percent, but employers in States meeting certain Federal requirements and having no delinquent Federal loans are eligible for a 5.4 percent credit, making the minimum, net Federal tax rate 0.8 percent.

Chart 2 shows the historical trend in the Federal taxable wage base from 1940 to 1989. The wage base was held constant at $3,000 until 1971, but has been increased three times since then. The chart also shows the erosion of the taxable wage base during the 1950's and 1960's relative to wage growth. If the taxable wage base had been indexed for wage growth since 1940, the current wage base would be over $46,000 instead of only $7,000.

Chart 3 depicts the historical trends in the statutory and effective Federal unemployment tax rates. The effective tax rate equals FUTA revenue as a percent of total covered wages. Although the statutory tax rate doubled from 0.4 percent in the late 1960s to 0.8 percent in the late 1980s, the effective tax rate fluctuated between about 0.2 and 0.3 percent.

CHART 2. FEDERAL UC TAXABLE ANNUAL WAGE BASE IN CURRENT AND WAGE-ADJUSTED DOLLARS, 1940–89

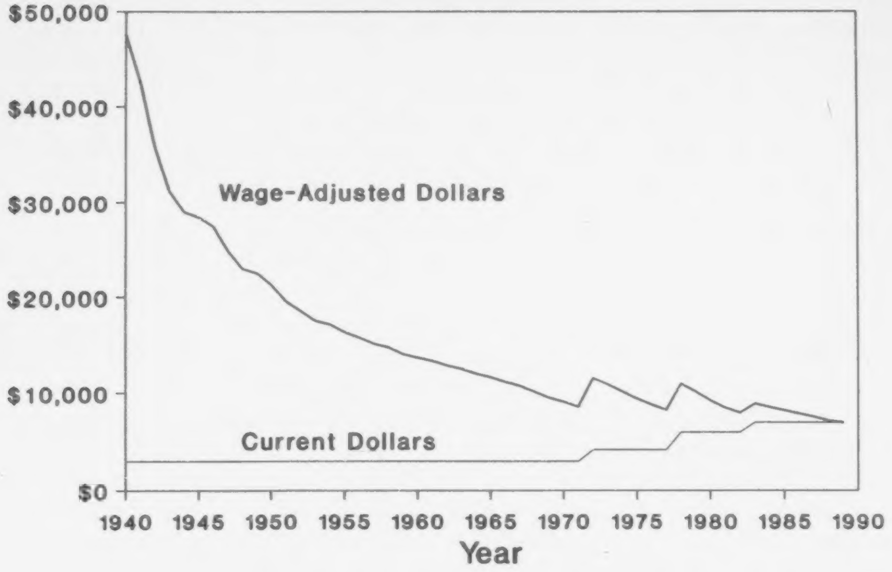


CHART 3. HISTORY OF FEDERAL UNEMPLOYMENT TAX RATE, 1954–88

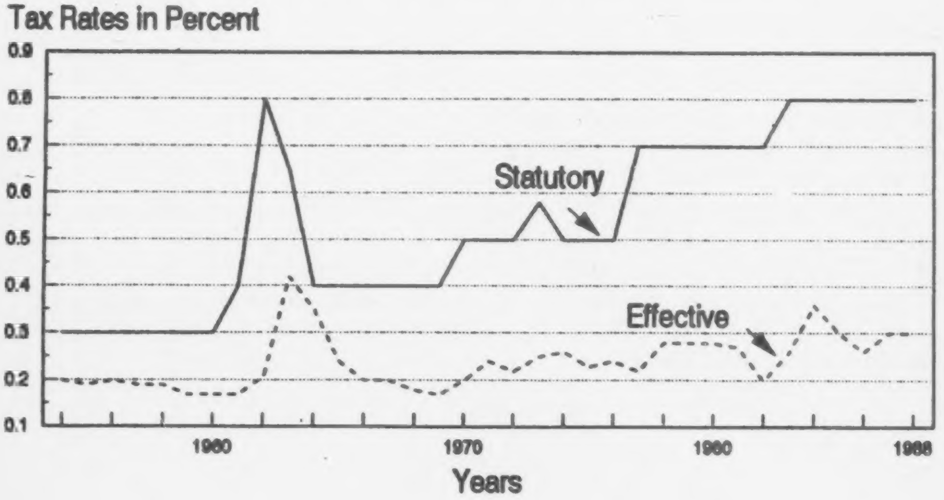
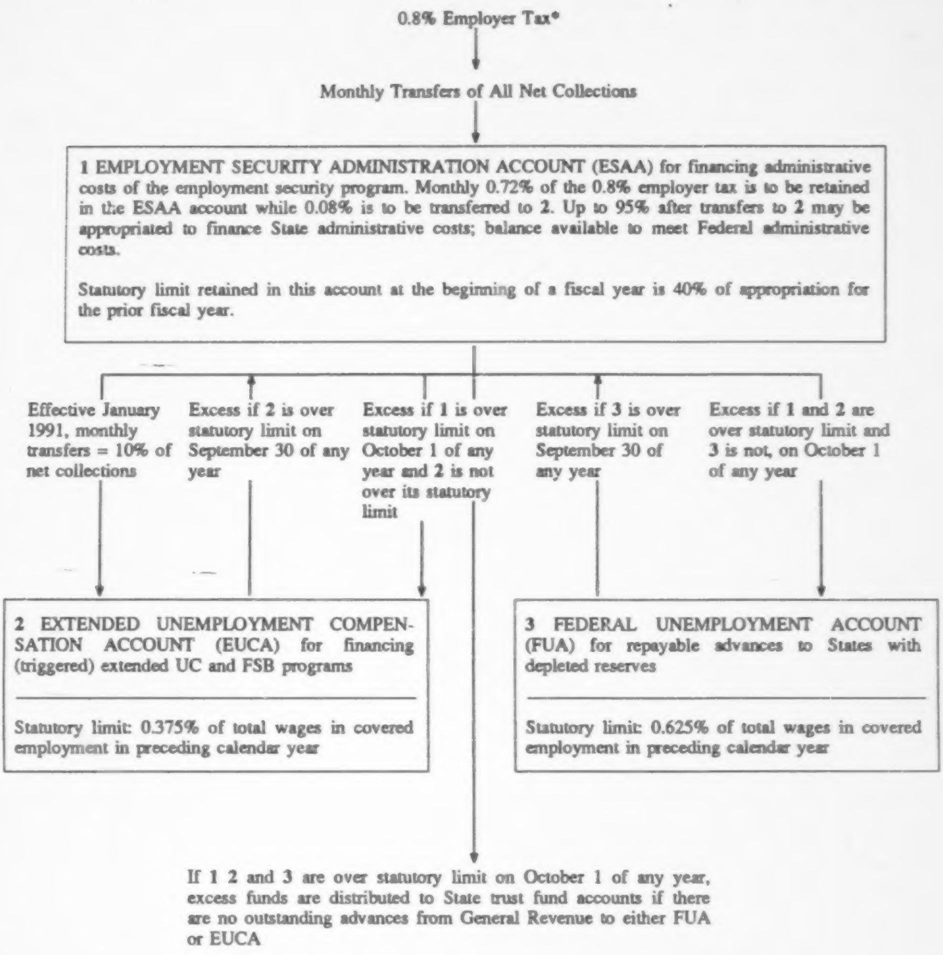


CHART 4. FLOW OF FUTA FUNDS UNDER EXISTING FEDERAL STATUTES



0.8% Employer Tax*

Monthly Transfers of All Net Collections

1 EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT (ESAA) for financing administrative costs of the employment security program. Monthly 0.72% of the 0.8% employer tax is to be retained in the ESAA account while 0.08% is to be transferred to 2. Up to 95% after transfers to 2 may be appropriated to finance State administrative costs; balance available to meet Federal administrative costs.

Statutory limit retained in this account at the beginning of a fiscal year is 40% of appropriation for the prior fiscal year.

Effective January 1991, monthly transfers = 10% of net collections

Excess if 2 is over statutory limit on September 30 of any year

Excess if 1 is over statutory limit on October 1 of any year and 2 is not over its statutory limit

Excess if 3 is over statutory limit on September 30 of any year

Excess if 1 and 2 are over statutory limit and 3 is not, on October 1 of any year

2 EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT (EUCA) for financing (triggered) extended UC and FSB programs

Statutory limit: 0.375% of total wages in covered employment in preceding calendar year

3 FEDERAL UNEMPLOYMENT ACCOUNT (FUA) for repayable advances to States with depleted reserves

Statutory limit: 0.625% of total wages in covered employment in preceding calendar year

If 1 2 and 3 are over statutory limit on October 1 of any year, excess funds are distributed to State trust fund accounts if there are no outstanding advances from General Revenue to either FUA or EUCA

*Effective tax, after 5.4 percent (2.7% prior to 1985) is offset against 6.2 percent (3.5% prior to 1985) Federal unemployment tax. Legislation enacted in 1990 extends the 0.2% temporary FUTA tax through 1995, resulting in the 0.8% effective tax rate.

SOURCE: National Foundation for Unemployment Compensation and Workers' Compensation, "Highlights of State Unemployment Compensation Laws," January 1991.

State unemployment taxes

The States finance their programs and half of the extended benefits program with employer payroll taxes imposed on at least the first $7,000 paid annually to each employee.[1] States generally adopt a taxable wage base at least as high as the Federal level because they otherwise would lose the 5.4 percent credit to employers on the difference between the Federal taxable wage base and State taxable wage base. Table 4 shows that as of January 1991, 37

---

[1] Alaska, New Jersey, and Pennsylvania also tax employees.

States had taxable wage bases higher than the Federal taxable wage base, ranging up to $22,400 in Alaska.

Although the standard State tax rate is 5.4 percent, State tax rates based on unemployment experience can range from zero on some employers in 15 States up to a maximum as high as 10 percent in 3 States.

Estimated national average State tax rates on taxable wages and total wages for 1990 were 2.0 and 0.7 percent, respectively. Estimated average State tax rates on taxable wages ranged from 0.6 percent in South Dakota to 5.4 percent in Puerto Rico. Estimated average State tax rates on total wages varied from 0.3 percent in five States to 2.9 percent in Puerto Rico.

TABLE 4.—STATE UNEMPLOYMENT TAX BASES AND RATES

State	1991 tax base	1991 experience rates[1]		Estimated 1990 average tax rates as a percent of—	
		Minimum	Maximum	Taxable wages	All wages
U.S. average	(2)	NA	NA	2.0	0.7
Alabama	$8,000	0.2	6.8	1.4	.6
Alaska	22,400	1.0	6.5	4.1	2.8
Arizona	(2)	.1	5.4	1.2	.4
Arkansas	8,000	0	6.0	2.2	1.0
California	(2)	.1	5.4	2.0	.6
Colorado	10,000	0	5.4	1.5	.7
Connecticut	7,100	.5	6.4	1.9	.5
Delaware	8,500	.1	8.0	2.3	1.0
District of Columbia	8,000	.1	5.4	1.7	.5
Florida	(2)	.1	5.4	.7	.3
Georgia	8,500	.01	8.64	1.4	.5
Hawaii	21,400	0	5.4	1.3	.9
Idaho	18,000	.1	6.8	1.7	1.2
Illinois	9,000	.2	6.7	2.6	.9
Indiana	(2)	.02	5.4	1.4	.5
Iowa	12,200	0	9.0	1.6	.8
Kansas	8,000	.025	5.4	2.4	1.0
Kentucky	8,000	.3	10.0	2.1	.8
Louisiana	8,500	.3	6.0	2.3	1.0
Maine	(2)	.5	6.5	2.2	.9
Maryland	(2)	.1	6.0	1.1	.3
Massachusetts	(2)	1.2	7.2	2.7	.9
Michigan	9,500	0	10.0	3.9	1.3
Minnesota	13,300	.1	9.0	2.0	1.0
Mississippi	(2)	.1	6.4	1.2	.5

TABLE 4.—STATE UNEMPLOYMENT TAX BASES AND RATES—Continued

State	1991 tax base	1991 experience rates[1]		Estimated 1990 average tax rates as a percent of—	
		Minimum	Maximum	Taxable wages	All wages
Missouri	(2)	0	7.8	1.4	.5
Montana	13,400	0	6.4	1.3	.9
Nebraska	(2)	.0	5.4	1.1	.4
Nevada	13,800	.25	5.4	1.4	.8
New Hampshire	(2)	.01	6.5	.8	.3
New Jersey	14,400	.3	7.0	1.7	.8
New Mexico	11,700	.1	5.4	1.7	1.0
New York	(2)	0	6.4	1.9	.5
North Carolina	11,500	.1	5.7	.8	.4
North Dakota	11,800	.1	5.4	1.6	.9
Ohio	8,000	0	7.3	2.6	.9
Oklahoma	9,700	.1	6.2	1.8	.7
Oregon	16,000	.9	5.4	2.8	1.7
Pennsylvania	8,000	.3	9.2	3.5	1.2
Puerto Rico	(2)	(3)	(3)	5.4	2.9
Rhode Island	14,400	.8	8.4	2.5	1.3
South Carolina	(2)	.19	5.4	1.9	.7
South Dakota	(2)	0	9.5	.6	.3
Tennessee	(2)	.15	10.0	1.5	.6
Texas	9,000	0	6.0	2.3	.9
Utah	14,500	.1	8.0	1.5	.8
Vermont	8,000	.4	8.4	3.0	1.2
Virginia	8,000	0	6.2	.8	.3
Virgin Islands	17,000	.1	9.0	1.9	1.4
Washington	16,800	.48	5.4	2.3	1.4
West Virginia	8,000	0	7.5	2.2	.9
Wisconsin	10,500	.27	8.9	2.5	1.1
Wyoming	10,500	0	8.5	3.1	1.5

---

[1] Actual rates could be higher if State has an additional tax.

[2] The 1991 tax base is $7,000 except as otherwise shown in this column.

[3] Puerto Rico is not experience rated. The rate in Puerto Rico is 5.4% of $7,000.

NA—Means not applicable.

Note: This table shows State unemployment tax levels. It does not include the Federal unemployment tax.

Source: Department of Labor (based on estimates by State agencies).

Table 5 shows recent State data on unemployment compensation covered employment, wages, taxable wages, the ratio of taxable to total wages, and average weekly wages. The ratio of taxable wages to total wages varied from 0.22 in New York to 0.65 in Montana.

TABLE 5.—12-MONTH AVERAGE EMPLOYMENT AND WAGES COVERED BY UNEMPLOYMENT COMPENSATION (UC) FOR PERIOD ENDING MARCH 1990

State	Average employment (thousands)	Total wages (millions)	Taxable wages (millions)	Ratio of taxable wages to total wages	Average weekly total wages
United States	105,300	$2,373,304	$755,188	0.32	$433
Alabama	1,510	29,261	10,243	.35	373
Alaska	207	6,177	3,069	.50	573
Arizona	1,430	29,702	8,921	.30	400
Arkansas	860	14,912	5,545	.37	334
California	12,744	320,665	85,137	.27	484
Colorado	1,418	31,018	11,557	.37	421
Connecticut	1,626	45,185	10,685	.24	534
Delaware	336	7,886	2,400	.30	451
District of Columbia	450	13,725	3,089	.23	586
Florida	5,199	104,521	33,978	.33	387
Georgia	2,818	60,330	19,192	.32	412
Hawaii	483	10,391	5,762	.55	414
Idaho	358	6,464	3,520	.54	348
Illinois	5,028	122,459	37,684	.31	468
Indiana	2,381	49,534	14,683	.30	400
Iowa	1,146	21,136	8,863	.42	355
Kansas	1,014	19,714	8,562	.43	374
Kentucky	1,342	25,484	8,732	.34	365
Louisiana	1,471	29,030	10,039	.35	380
Maine	516	9,832	3,097	.31	367
Maryland	1,986	45,886	12,562	.27	444
Massachusetts	2,958	75,475	21,450	.28	491
Michigan	3,796	94,159	28,384	.30	477
Minnesota	2,014	45,048	17,813	.40	430
Mississippi	875	14,768	5,222	.35	325
Missouri	2,197	45,791	13,015	.28	401
Montana	268	4,553	2,973	.65	327
Nebraska	677	11,974	3,700	.31	340
Nevada	579	12,426	6,327	.51	413
New Hampshire	504	10,951	3,164	.29	418
New Jersey	3,538	95,940	36,663	.38	521
New Mexico	514	9,425	3,954	.42	353
New York	7,966	220,948	48,131	.22	533
North Carolina	2,997	58,054	25,249	.43	373
North Dakota	231	3,897	1,547	.40	324

TABLE 5.—12-MONTH AVERAGE EMPLOYMENT AND WAGES COVERED BY UNEMPLOYMENT COMPENSATION (UC) FOR PERIOD ENDING MARCH 1990—Continued

State	Average employment (thousands)	Total wages (millions)	Taxable wages (millions)	Ratio of taxable wages to total wages	Average weekly total wages
Ohio	4,630	101,846	30,493	.30	423
Oklahoma	1,096	21,177	8,025	.38	372
Oregon	1,173	23,818	11,730	.49	391
Pennsylvania	4,892	109,356	32,200	.29	430
Puerto Rico	839	10,379	3,949	.38	238
Rhode Island	446	9,569	4,046	.42	413
South Carolina	1,438	26,881	9,024	.34	359
South Dakota	253	3,934	1,335	.34	299
Tennessee	2,069	40,622	12,976	.32	378
Texas	6,591	143,309	49,633	.35	418
Utah	630	12,015	5,470	.46	367
Vermont	251	4,911	1,623	.33	377
Virginia	2,642	56,899	16,980	.30	414
Virgin Islands	41	800	380	.48	371
Washington	1,977	42,875	20,997	.49	417
West Virginia	574	11,314	3,620	.32	379
Wisconsin	2,142	43,464	16,536	.38	390
Wyoming	179	3,413	1,258	.37	367

Source: UI Data Summary, 3rd Quarter CY 90, Dec. 1990.

ADMINISTRATIVE FINANCING AND ALLOCATION

State unemployment compensation administrative expenses are Federally financed. A portion of revenue from the Federal unemployment tax (FUTA) is designated for administration and to maintain a system of public employment offices.

FUTA revenue flows into three Federal accounts in the Unemployment Trust Fund: (1) the Employment Security Administration Account (ESAA), (2) the Extended Unemployment Compensation Account (EUCA), and (3) the Federal Unemployment Account (FUA). Authorized by title IX of the Social Security Act, ESAA finances administrative costs associated with Federal and State unemployment compensation and employment services.

Under current law, 90 percent of FUTA revenue is allocated to ESAA and 10 percent to EUCA. FUA receives funds indirectly if they overflow from ESAA and EUCA. Funds for administration are limited to 95 percent of the estimated annual revenue that is expected to flow to ESAA from the Federal unemployment tax. Funds for administration may be augmented by three-eighths of the amount in ESAA at the beginning of the fiscal year, or $150 million, whichever is less, if the rate of insured unemployment is at least 15 percent higher than it was over the corresponding calendar quarter in the immediately preceding year.

Title III of the Social Security Act authorizes payment to each State with an approved unemployment compensation law such amounts as are deemed necessary for the proper and efficient administration of such law during the fiscal year. Allocations are based on: (1) the population of the State; (2) an estimate of the number of persons covered by the State unemployment insurance law; (3) an estimate of the cost of proper and efficient administration of such law; and (4) such other factors as the Secretary of Labor finds relevant.

Subject to the limit of available resources, the allocation of State grants for administration is the summation of resources derived in two major areas, the Unemployment Insurance Service (UI) and the Employment Service (ES). Each area has its own allocation methodology subject to general constraints set forth in the Social Security Act and the Wagner-Peyser Act.

Each year, as part of the development of the President's Budget, the Department of Labor in conjunction with the Department of Treasury, estimates revenue expected from FUTA and the appropriate amount to be available for administration (and the Federal share of extended benefits). The estimate of FUTA revenues is based on several factors: (1) a wage base of $7,000 per employee; (2) a tax rate of 0.8 percent (0.72 percentage point for administration and 0.08 percentage point for extended benefits); (3) the administration's projection of the level of unemployment and the growth in wages; and (4) the level of covered employment subject to FUTA. Additionally, a determination is made based on the administration's forecast for unemployment as to whether the rate will increase by at least 15 percent.

Each year the President's Budget sets forth an estimate of national unemployment in terms of the volume of unemployment claims per week. This is characterized as average weekly insured unemployment (AWIU). A portion of AWIU is expressed as "base" and the remainder as "contingency." At the present time, the base is set at the level of resources required to process an average weekly volume of 1.8 million weeks of unemployment.

Resources available to each State to administer its unemployment compensation program (i.e., process claims and pay benefits) are provided from either "base" funds or "contingency" funds. At the beginning of the fiscal year, only the base funds are allocated while contingency funds are allocated on a needs basis as workload materializes. Base funds are distributed to the State for use throughout the fiscal year and are available regardless of the level of unemployment (workload) realized. If a State processes workloads in excess of the base level, it receives contingency funds determined by the extent of the resources required to process the additional workload.

The allocation of the base UI grant funds to each State is made by:

(1) Projecting the workloads that each State is expected to process.

These projections are then adjusted so that the sum across States for each workload item is equal to the budgeted base workload.

(2) Determining the staff required to process each State's projected workload.

The staff requirements are computed by multiplying the projected workloads by minutes per unit (MPU) and dividing the result by the number of work minutes per staff year for each State. The MPUs were derived from work measurement studies conducted in each State that establish the number of minutes required to perform specific tasks. The MPUs developed from the studies are necessarily reduced so that the total of computed staff years for each workload item across States equals the staff years available in the appropriation. The MPUs are reduced according to a complex mathematical formula that takes into account workload volume and the range of MPUs.

(3) Multiplying the final staff-year allocations for each State by the cost per staff year (i.e., State salary and benefit level) to determine dollar funding levels.

(4) Allocating overhead resources (administrative and management staff and nonpersonal services) using a methodology driven by the program staff years developed in the UI base allocation. In summary, the administrative staff allocation is calculated by multiplying program staff times a State's administrative staff historical rate. The estimates of the number of administrative staff are then multiplied by each State's cost per staff year and adjusted so that the allocated sum equals that in the appropriation for administrative staff. Nonpersonal services are calculated using an historical staff year unit cost increased annually for inflation provided in the budget. The revised unit cost is multiplied by staff years to determine the allocation, which is adjusted to match budgeted dollars.

Each Department of Labor regional office may redistribute resources among the States in its area with national office approval.

BENEFITS

Coverage

In order to qualify for benefits, an unemployed person usually must have worked recently for a covered employer for a specified period of time and for a certain amount of wages. About 105 million individuals are covered by UC. This is approximately 97 percent of all wage and salary workers or about 88 percent of all employed persons.

The Federal Unemployment Tax Act (FUTA) covers certain employers that State laws also must cover for employers in the States to qualify for the 5.4 percent Federal credit. Since employers in the States would lose this credit and their employees would not be covered if the States did not have this coverage, all States cover the following groups: (1) Except for nonprofit organizations, State-local governments, certain agricultural labor, and certain domestic service, FUTA covers employers who paid wages of at least $1,500 during any calendar quarter or who employed at least one worker in at least 1 day of each of 20 weeks in the current or prior year; (2) FUTA covers agricultural labor for employers who paid cash wages of at least $20,000 for agricultural labor in any calendar quarter or who employed 10 or more workers in at least 1 day in each of 20 different weeks in the current or prior year. In addition, section 3306(c)(1) of FUTA exempts certain alien farmworkers until January 1993; and (3) FUTA covers domestic service employers who paid cash wages of $1,000 or more for domestic service during any calendar quarter in the current or prior year.

FUTA requires coverage of nonprofit organization employers of at least four workers for 1 day in each of 20 different weeks in the current or prior year and State-local governments without regard to the number of employees. Nonprofit and State-local government organizations are not required to pay Federal unemployment taxes; they may choose instead to reimburse the system for benefits paid to their laid-off employees.

States may cover certain employment not covered by FUTA, but most States have not expanded FUTA coverage significantly. The excluded coverage involves: (1) self-employment; (2) certain agricultural labor and domestic service; (3) service for relatives; (4) service of patients in hospitals; (5) certain student interns; (6) certain alien farmworkers; (7) certain seasonal camp workers; and (8) railroad workers.

TABLE 6.—INSURED UNEMPLOYMENT AS A PERCENT OF TOTAL UNEMPLOYMENT

Year	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Avg.
1967	52	52	54	54	50	30	39	41	33	33	35	47	43
1968	57	50	52	50	45	26	34	38	33	34	38	48	42
1969	54	54	52	48	43	27	35	36	31	33	40	51	41
1970	57	54	52	53	53	36	42	45	42	44	48	53	48
1971	58	58	61	59	56	42	45	48	44	46	47	55	52
1972	56	58	56	52	49	36	41	38	33	34	38	47	45
1973	51	46	46	44	43	31	36	37	34	38	38	48	41
1974	53	54	57	60	55	40	43	44	40	42	48	60	50
1975	66	73	77	81	79	72	77	79	73	74	76	80	76
1976	78	75	76	73	72	58	66	66	60	59	60	63	67
1977	67	66	66	66	59	46	52	49	47	48	49	57	56
1978	54	54	50	47	44	36	39	42	35	37	34	43	43
1979	48	48	47	47	42	33	39	38	37	38	40	49	42
1980	52	51	53	52	49	45	49	49	55	49	50	54	50
1981	54	50	48	46	40	35	37	37	36	34	38	41	41
1982	47	44	48	49	45	40	42	42	43	48	49	47	45
1983	50	53	51	53	53	40	39	36	34	33	39	41	44
1984	40	38	38	36	34	30	31	31	30	31	31	38	34
1985	40	41	41	39	32	28	30	30	28	27	32	37	34
1986	38	36	37	35	32	29	32	32	29	30	32	37	33
1987	37	37	38	35	31	28	30	29	28	26	29	34	32
1988	37	37	37	35	31	28	30	29	27	27	30	34	32
1989	35	35	40	37	30	29	33	33	29	31	29	38	33
1990	40	42	44	41	37	33	36	34	32	34	34	40	37

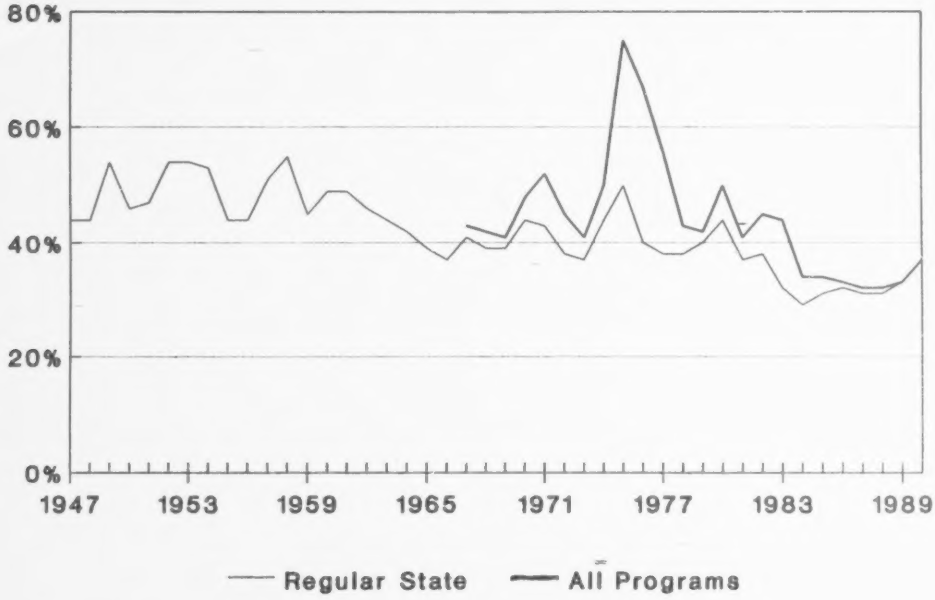
Source: USDOL/ETA/UIS, Division of Actuarial Services.

The number of covered workers receiving unemployment compensation

Although the UC system covers about 88 percent of all employed persons, table 6 shows that on average only 37 percent of unemployed persons were receiving UC benefits in 1990. This compares with a peak of 81 percent of the unemployed receiving UC benefits in April 1975 and a low point of 26 percent in October 1987.

Chart 5 shows the proportion of unemployed receiving benefits. The thin bottom line shows the percentage of unemployed receiving UC from regular State programs; the thicker top line shows the percentage aided by all UC programs combined, namely, the Federal-State EB program, temporary supplemental benefit programs, and UC for unemployed Federal workers and ex-servicemembers. Despite high unemployment during the early 1980s, there was a downward trend in the proportion of unemployed persons receiving regular State benefits until the mid-1980s.

CHART 5. UNEMPLOYMENT COMPENSATION WEEKS CLAIMED AS A PERCENT OF ALL UNEMPLOYMENT WEEKS, REGULAR STATE AND ALL PROGRAMS, 1947–90



Source: Chart prepared by CRS based on data from the U.S. Department of Labor.

In May 1988, Mathematica Policy Research (MPR), under contract to the U.S. Department of Labor, released a study on the decline in the proportion of unemployed receiving benefits during the 1980's. This analysis did not find a single cause for the decline but instead found statistical evidence that the following factors contributed to the decline in UC claims (the figures in parentheses show the share of the decline attributed to each factor):

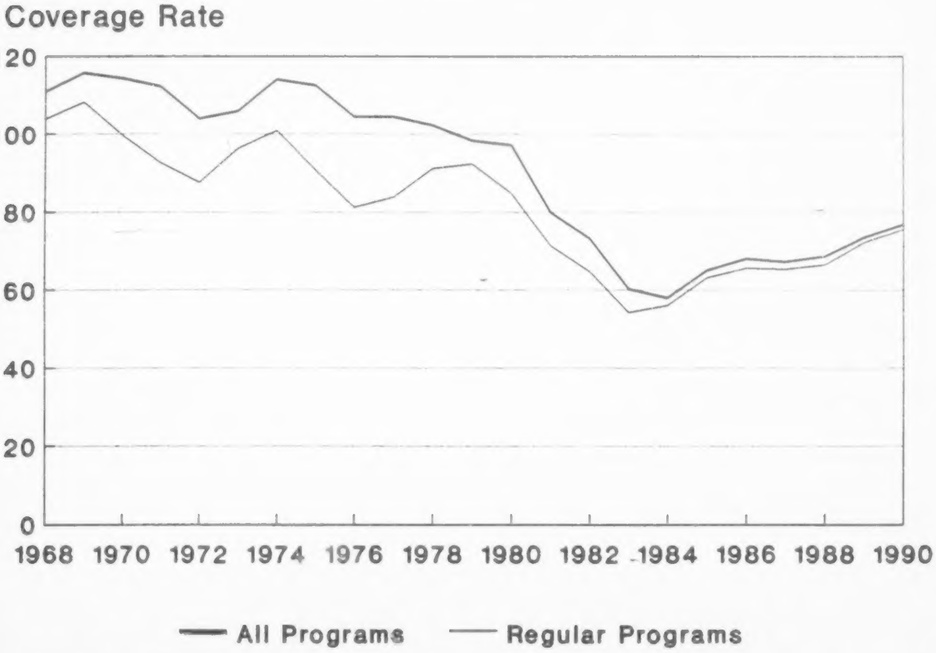
—the decline in the proportion of unemployed from manufacturing industries (4–18 percent);

- —geographic shifts in composition of the unemployed among regions of the country (16 percent);
- —changes in State program characteristics (22–39 percent):
  - —increase in the base period earnings requirements (8–15 percent);
  - —increase in income denials for UC receipt (10 percent); and
  - —tightening up other nonmonetary eligibility requirements (3–11 percent);
- —changes in Federal policy: partial taxation of UC benefits (11–16 percent);
- —changes in unemployment as measured by the CPS (1–12 percent).

The group of unemployed most likely to be insured are job losers. Chart 6 shows the number of unemployment compensation claimants measured as a percentage of the number of job losers. This coverage ratio remained fairly stable from 1968 through 1979. Over that 12-year span, there were from 90 to 110 recipients of regular State UC for every 100 job losers. This ratio fluctuated somewhat over the business cycle, but it was otherwise quite stable.

Beginning in 1980, the ratio of UC recipients to job losers fell sharply, reaching an all-time low in 1983 when there were fewer than 60 regular UC recipients for every 100 job losers. Since 1983, the coverage ratio has increased somewhat, so that there are now about 75 regular UC claimants for every 100 job losers. However, the ratio remains well below its pre-1980 level.

CHART 6. RATIO OF INSURED UNEMPLOYMENT TO JOB LOSERS (YEARLY AVERAGES), 1968–90



Note: Insured unemployment data includes the Virgin Islands and Puerto Rico, but the data for job losers do not include these territories.

Source: Chart prepared by CRS based on data from the Economic Report of the President, 1990, and U.S. Department of Labor.

Eligibility

States have developed diverse and complex methods for determining UC eligibility. In general there are three major factors: (1) the amount of recent employment and earnings; (2) demonstrated ability and willingness to seek and accept suitable employment; and (3) certain disqualifications related to a claimant's most recent job separation or job offer refusal.

Monetary qualifications

Table 7 shows the State monetary qualification requirements in the base year for the minimum and maximum weekly benefit amounts, and for the maximum total potential benefits. The base year is a recent 1-year period that most States (47) define as the first 4 of the last 5 completed calendar quarters before the unemployed person claims benefits. Most States require employment in at least 2 calendar quarters of the base year. Qualifying wages for the minimum weekly benefit amount vary from $150 in Hawaii to $3,640 in Oklahoma. For the maximum weekly benefit amount, the range is $3,349 in Indiana to $23,816 in Colorado. The range of qualifying wages for the maximum total potential benefit, which is the product of the maximum weekly benefit amount and the maximum potential weeks of benefits, is from $4,800 in Puerto Rico to $23,816 in Colorado.

TABLE 7.—MONETARY QUALIFICATION REQUIREMENTS FOR MINIMUM AND MAXIMUM WEEKLY BENEFIT AMOUNTS AND MAXIMUM TOTAL POTENTIAL BENEFITS IN 1991 [1]

State	Required total earnings in base year			Minimum work in base year (quarters) [3]
	For minimum weekly benefit	For maximum weekly benefit	For maximum potential benefits [2]	
Alabama	$1,032	$7,176	$11,699	2Q
Alaska	1,000	22,250	22,250	2Q
Arizona	1,500	6,169	12,869	2Q
Arkansas	1,170	11,440	17,160	2Q
California	1,125	8,708	10,918	
Colorado	1,000	23,816	23,816	
Connecticut	600	10,800	10,800	2Q
Delaware	966	10,350	10,350	
District of Columbia	900	10,108	15,236	2Q
Florida	400	9,000	23,400	2Q
Georgia	1,350	9,250	19,238	2Q
Hawaii	150	8,250	8,250	2Q
Idaho	1,430	6,695	16,900	2Q
Illinois	1,600	10,881	10,881	2Q
Indiana	2,500	3,349	9,984	2Q

TABLE 7.—MONETARY QUALIFICATION REQUIREMENTS FOR MINIMUM AND MAXIMUM WEEKLY BENEFIT AMOUNTS AND MAXIMUM TOTAL POTENTIAL BENEFITS IN 1991 [1]—Continued

State	Required total earnings in base year			Minimum work in base year (quarters) [3]
	For minimum weekly benefit	For maximum weekly benefit	For maximum potential benefits [2]	
Iowa	960	5,348	14,508	2Q
Kansas	1,650	6,660	17,316	2Q
Kentucky	1,500	16,751	16,751	2Q
Louisiana	1,200	6,788	17,428	2Q
Maine	2,176	6,312	14,664	2Q
Maryland	900	7,704	7,704	2Q
Massachusetts	1,200	8,460	23,500	....
Michigan	2,010	10,840	16,709	2Q
Minnesota	1,250	8,450	20,280	2Q
Mississippi	1,200	5,800	11,310	2Q
Missouri	1,500	5,667	13,260	2Q
Montana	1,176	7,878	16,641	2Q
Nebraska	1,200	4,150	11,229	2Q
Nevada	600	7,575	15,756	2Q
New Hampshire	2,800	23,500	23,500	2Q
New Jersey	2,060	9,700	16,975	2Q
New Mexico	1,151	5,752	7,670	2Q
New York	1,600	10,380	10,380	2Q
North Carolina	2,212	12,740	19,110	2Q
North Dakota	2,795	12,870	16,474	2Q
Ohio	1,702	7,840	10,192	2Q
Oklahoma	3,640	7,388	9,100	2Q
Oregon	1,000	19,760	19,760	2Q
Pennsylvania	1,320	11,560	11,560	2Q
Puerto Rico	280	4,800	4,800	2Q
Rhode Island	1,700	8,734	19,428	2
South Carolina	900	6,825	13,650	2Q
South Dakota	1,568	7,840	10,917	2Q
Tennessee	1,560	10,084	17,160	2Q
Texas	1,369	8,288	21,567	2Q
Utah	1,500	8,619	21,281	2
Vermont	1,438	8,190	8,190	2Q
Virginia	3,000	9,900	19,800	2Q
Virgin Islands	1,287	6,357	12,714	2Q
Washington	1,525	6,150	22,140	....

TABLE 7.—MONETARY QUALIFICATION REQUIREMENTS FOR MINIMUM AND MAXIMUM WEEKLY BENEFIT AMOUNTS AND MAXIMUM TOTAL POTENTIAL BENEFITS IN 1991 [1]—Continued

State	Required total earnings in base year			Minimum work in base year (quarters) [3]
	For minimum weekly benefit	For maximum weekly benefit	For maximum potential benefits [2]	
West Virginia	2,200	23,800	23,800	2
Wisconsin	1,428	7,650	14,625	2Q
Wyoming	1,500	8,000	16,667	2Q

[1] Based on benefits for total unemployment. Amounts payable can be stretched out over a longer period in the case of partial unemployment.

[2] Based on maximum weekly benefit amount paid for maximum number of weeks. Total potential benefits equal a worker's weekly benefit amount times this potential duration.

[3] Number of quarters of work in base year required to qualify for minimum benefits. "2Q" denotes that State directly or indirectly requires work in at least 2 quarters of the base year. States without an entry have the minimum work requirement specified as a wage amount.

Source: U.S. Department of Labor.

Since the beginning of 1990, 13 States increased the required earnings in the base year to qualify for the minimum weekly benefit amount. Thirty-eight States increased and 3 decreased the qualification requirement for the maximum weekly benefit amount. Forty States increased their qualification requirements for maximum potential benefits.

Ability to work and availability for work

All State laws provide that a claimant must be: (1) able to work; and (2) available for work. A claimant must meet these conditions continually to receive benefits.

Only minor variations exist in State laws setting forth the requirements concerning "ability to work." A few States specify that a claimant must be mentally and physically able to work.

"Available for work" is often translated to mean being ready, willing, and able to work. In addition to registration for work at a local employment office, most State laws require that a claimant actively seek work or make a reasonable effort to obtain work. Generally, a person may not refuse an offer of, or referral to, "suitable work" without good cause.

"Suitable work" is generally work in a claimant's customary occupation which meets certain health, safety, moral, and labor standards. Most State laws list certain criteria by which the "suitability" of a work offer is to be tested. The usual criteria include the degree of risk to a claimant's health, safety, and morals; the physical fitness and prior training, experience, and earnings of the person; the length of unemployment and prospects for securing local work in a customary occupation; and the distance of the available work from the claimant's residence. Generally, as the length of unemployment increases, the claimant is required to accept a wider range of jobs.

In addition, Federal law requires States to deny benefits provided under the extended benefit program to any individual who fails to accept any work that is offered in writing or is listed with the State employment service, or who fails to apply for any work to which he or she is referred by the State agency, if the work is within the person's capabilities, pays wages equal to the highest of the Federal or any State or local minimum wage, pays a gross weekly wage that exceeds the person's average weekly unemployment compensation benefits plus any supplemental unemployment compensation (usually private) payable to the individual, and is consistent with the State definition of "suitable" work in other respects.

States must refer extended benefits claimants to any job meeting these requirements. If the State, based on information provided by the individual, determines that the individual's prospects for obtaining work in his or her customary occupation within a reasonably short period are good, the determination of whether any work is "suitable work" is made in accordance with State law rather than the above.

There are certain circumstances under which Federal law provides that State and extended benefits may not be denied. A State may not deny benefits to an otherwise eligible individual for refusing to accept new work under any of the following conditions: (1) if the position offered is vacant directly due to a strike, lockout, or other labor dispute; (2) if the wages, hours, or other conditions of the work offered are substantially less favorable to the individual than those prevailing for similar work in the locality; (3) if, as a condition of being employed, the individual would be required to join a company union or to resign from or refrain from joining any bona fide labor organization. Further, benefits may not be denied solely on the grounds of pregnancy. The State is prohibited from canceling wage credits or totally denying benefits except in cases of misconduct, fraud, or receipt of disqualifying income.

There are also certain conditions under which Federal law requires that benefits be denied. For example, benefits must be denied to employees of educational institutions during summer (and other vacation periods) if they have a reasonable assurance of reemployment; to professional athletes between sport seasons; and to aliens not legally admitted to work in the United States.

Disqualifications

The major causes for disqualification from benefits are not being able to work or available for work, voluntary separation from work without good cause, discharge for misconduct connected with the work, refusal of suitable work without good cause, and unemployment resulting from a labor dispute. Disqualification for one of these reasons may result in a postponement of benefits for some prescribed period, a cancellation of benefit rights, or a reduction of benefits otherwise payable.

Of the 17.3 million "monetarily eligible" initial UC claims in fiscal year 1990, 22.0 percent were disqualified. This figure subdivides into 4.6 percent not being able to work or available for work, 6.4 percent voluntarily leaving a job without good cause, 3.5 percent being fired for misconduct on the job, 0.2 percent refusing suitable work, and 7.3 percent committing other disqualifying acts. The total disqualification rate ranged from a low of 6.8 percent in Tennessee to a high of 104.7 percent in Nebraska, with Colorado the next highest at 62.6 percent. (Note that a claimant can be disqualified for any week claimed, so it is possible for a claimant to be disqualified more times than the total number of that claimant's initial claims in the benefit year.)

Federal law requires that benefits provided under the extended benefits program will be denied to an individual for the entire spell of his or her unemployment if he or she was disqualified from receiving State benefits because of voluntarily leaving employment, discharge for misconduct, or refusal of suitable work. These benefits will be denied even if the disqualification were subsequently lifted with respect to the State benefits prior to reemployment. The person could receive these benefits, however, if the disqualification were lifted because he or she became reemployed and met the work or wage requirement of State law.

Ex-service members

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) established new requirements for the payment of benefits to ex-service members under the unemployment compensation for ex-service members (UCX) program. Under the act, benefits were limited to individuals who: (1) had 365 or more days of military service; (2) were discharged or released under honorable conditions; (3) did not resign or voluntarily leave the service (i.e., they were not eligible for reenlistment); and (4) were not released or discharged "for cause" as defined by the Department of Defense. The requirements applied to individuals who left Federal military service on or after July 1, 1981, but only for weeks of unemployment that began on or after August 13, 1981, the date of enactment of Public Law 97-35.

The Miscellaneous Revenue Act of 1982 (Public Law 97-362) modified the above eligibility requirements for ex-service members. Federal unemployment benefits are now payable to unemployed ex-service members who: (1) are separated under honorable conditions (and, in the case of officers, did not resign for the good of the service); and (2) have completed the first full term of active service they agreed to serve. Ex-service members who are separated prior to completing their first full term of active service can qualify for unemployment compensation benefits if they are separated under honorable conditions: (1) for the convenience of the Government under an early release program; (2) because of medical disqualification, pregnancy, parenthood, or any service-incurred injury or disability; (3) because of hardship; or (4) if they have served for 365 continuous days, because of personality disorder or inaptitude. In addition to these eligibility requirements, ex-service members must wait 4 weeks from the date of their separation from the service before they may receive benefits. The maximum number of weeks of benefits an ex-service member may receive based on employment in the military is 13.

Pension offset

The Unemployment Compensation Amendments of 1976 (Public Law 94-566) required all States to reduce an individual's unemployment compensation benefits by the amount of any governmental or private pension or retirement pay received by the individual. Public Law 96-364 modified this offset requirement.

Under current law, States are required to make the offset only in those cases in which the work-related pension was maintained or contributed to by a "base period" or "chargeable" employer. Entitlement to, and the amount and duration of, unemployment benefits are based on work performed during this State-specified base period. A "chargeable" employer is one whose account will be charged for unemployment compensation received by the individual.

States are allowed to reduce the amount of the offset by an amount consistent with any contribution the employee made toward the pension. For example, this allows States to limit the offset to one-half of the amount of a social security pension received by an individual who qualifies for unemployment benefits.

Taxation of unemployment insurance benefits

The Tax Reform Act of 1986 (Public Law 99-514) made all unemployment compensation taxable after December 31, 1986. The Revenue Act of 1978 first made a portion of unemployment compensation benefits taxable beginning January 1, 1979. Generally, the unemployment insurance benefits subject to Federal tax was equal to the lower of the amount of unemployment compensation or one-half the excess of adjusted gross income, unemployment insurance payments, and excludable disability income over $20,000 for single taxpayers and over $25,000 for married taxpayers filing jointly. Beginning January 1, 1983, these amounts were changed to $12,000 for single taxpayers and $18,000 for married taxpayers filing jointly.

Table 8 illustrates the effect of taxing all unemployment compensation benefits for calendar year 1990. This table understates the impact of taxation because total unemployment compensation benefits on the current population survey (CPS) are equal to only about two-thirds of total benefits paid out.

TABLE 8.—ESTIMATED EFFECT OF TAXING UNEMPLOYMENT COMPENSATION BENEFITS, BY INCOME CLASS, 1992

Level of individual or couple income [1]	Number of recipients of unemployment compensation (in thousands)	Number affected by taxation of benefits (in thousands)	Percentage affected by taxation [2]	Total amount of unemployment compensation benefits (in millions of dollars)	Total amount of taxes on benefits (in millions of dollars)	Taxes as a percent of total benefits [3]
Less than $10,000	1,231	475	38.6	2,079	86	4.2
$10,000 to $15,000	881	722	82.0	1,647	180	10.9
$15,000 to $20,000	841	794	94.4	1,681	288	17.2
$20,000 to $25,000	772	762	97.5	1,497	282	19.5
$25,000 to $30,000	768	756	98.3	1,491	247	16.6
$30,000 to $40,000	1,104	1,102	99.7	1,930	325	16.9
$40,000 to $50,000	911	907	99.6	1,566	255	16.3
$50,000 to $100,000	1,003	1,003	100.0	1,883	472	25.0
At least $100,000	106	106	100.0	197	62	31.4
All	7,616	6,616	86.9	13,972	2,208	15.8

[1] Cash income (based on income of tax filing unit) plus capital gains realizations.

[2] The percentage affected may seem high for the lowest two income groups. However, about 60 percent of the recipients in those categories are single persons without dependents whose tax entry point is $5,300. In addition, the presence of unemployment compensation benefits reduces the amount of the earned income tax credit in the phaseout range of the credit.

[3] Figures shown were calculated from the data used in the prior two columns before those data were rounded.

Note: Aggregate unemployment compensation benefits on the CPS are equal to only about two-thirds of total benefits paid out. The number of recipients is also understated on the CPS.

Source: Congressional Budget Office, based on data from the Current Population Survey (CPS).

Amount and duration of weekly benefits

In general, the States set weekly benefit amounts as a fraction of the individual's average weekly wage up to some State-determined maximum. The total maximum duration available under current law is 39 weeks. The permanent, regular State programs usually provide up to 26 weeks. The permanent Federal-State extended benefits program provides up to 13 additional weeks in States where unemployment rates are relatively high.

The State-determined weekly benefit amounts generally replace between 50 and 70 percent of the individual's average weekly pretax wage up to some State-determined maximum. The average weekly wage is often calculated only from the calendar quarter in the base year in which the claimant's wages were highest. The State-determined maximum weekly benefit amounts generally vary between 50 and 70 percent of the average weekly covered wage in each State. Individual wage replacement rates tend to vary inversely with the claimant's average weekly pretax wage with high wage earners receiving lower wage replacement rates. Partly as a result, the national average weekly benefit amount as a percent of the average weekly covered wage was only 37 percent in 1990.

Table 9 shows the minimum and maximum weekly benefit amounts and potential duration for each State program. In fiscal year 1990, the national average weekly benefit amount was $161 and the average duration was 13.5 weeks, making the average total benefits $2,176. The minimum weekly benefit amounts for 1991 vary from $5 in Hawaii to $68 in Alaska. The maximum weekly benefit amounts range from $96 in Indiana to $423 in Massachusetts. Most States vary the duration of benefits with the amount of earnings the claimant has in the base year. Ten States provide the same duration for all claimants. The minimum durations range from 5 weeks in Oregon to 26 weeks in 9 States. The maximum duration is 26 weeks in 50 States. Only Puerto Rico has a maximum duration of fewer than 26 weeks at 23 weeks. Two States have maximum durations longer than 26 weeks, up to 30 weeks in Massachusetts and Washington.

Since the beginning of 1990, 15 States increased their minimum weekly benefit amounts. Forty-two States raised their maximum weekly benefit amounts. Two States lowered their minimum potential durations while three States increased them.

TABLE 9.—AMOUNT AND DURATION OF WEEKLY BENEFITS FOR TOTAL UNEMPLOYMENT UNDER THE REGULAR STATE PROGRAMS

State	1991 weekly benefit amount [1]		1990 average weekly benefit	1991 potential duration (weeks)		1990 average duration (weeks)
	Minimum	Maximum		Minimum	Maximum	
Alabama	$22	$150	$116	15	26	10
Alaska	44–68	212–284	163	16	26	15
Arizona	40	165	135	12	26	14
Arkansas	39	220	133	10	26	12
California	40	210	131	14	26	14
Colorado	25	229	168	13	26	12
Connecticut	15–22	270–320	201	26	26	15
Delaware	20	225	175	24	26	12
District of Columbia	13	293	213	26	26	18
Florida	10	225	146	10	26	13
Georgia	37	185	143	9	26	9
Hawaii	5	275	183	26	26	11
Idaho	44	206	145	10	26	11
Illinois	51	206–270	170	26	26	16
Indiana	40	96–161	109	9	26	10
Iowa	27–33	186–228	161	11	26	12
Kansas	55	222	171	10	26	14
Kentucky	22	199	136	15	26	12
Louisiana	10	181	102	8	26	15
Maine	33–49	188–282	159	21	26	13

TABLE 9.—AMOUNT AND DURATION OF WEEKLY BENEFITS FOR TOTAL UNEMPLOYMENT UNDER THE REGULAR STATE PROGRAMS—Continued

State	1991 weekly benefit amount [1]		1990 average weekly benefit	1991 potential duration (weeks)		1990 average duration (weeks)
	Minimum	Maximum		Minimum	Maximum	
Maryland	25–33	215	170	26	26	15
Massachusetts	14–21	282–423	217	10	30	18
Michigan	59	276	203	15	26	13
Minnesota	38	260	190	10	26	15
Mississippi	30	145	111	13	26	12
Missouri	33	170	135	15	26	13
Montana	48	193	137	8	26	13
Nebraska	20	144	120	20	26	11
Nevada	16	202	163	12	26	12
New Hampshire	35	168	128	26	26	10
New Jersey	61	291	207	15	26	16
New Mexico	35	177	126	19	26	16
New York	40	260	181	26	26	18
North Carolina	21	245	152	13	26	8
North Dakota	43	198	136	12	26	12
Ohio	42	196–291	155	20	26	13
Oklahoma	16	197	150	20	26	12
Oregon	57	247	162	5	26	13
Pennsylvania	35–40	291–299	189	16	26	15
Puerto Rico	7	120	79	23	23	14
Rhode Island	39–49	269–334	194	15	26	15
South Carolina	20	175	130	15	26	9
South Dakota	28	140	120	18	26	11
Tennessee	30	165	113	12	26	9
Texas	37	224	162	9	26	15
Utah	14	221	163	10	26	11
Vermont	26	182	149	26	26	14
Virginia	60	198	146	12	26	8
Virgin Islands	32	163	127	13	26	12
Washington	61	246	169	16	30	14
West Virginia	24	251	146	26	26	13
Wisconsin	42	225	171	13	26	12
Wyoming	38	200	159	11	26	14

---

[1] A range of amounts is shown for those States that provide dependents' allowances.

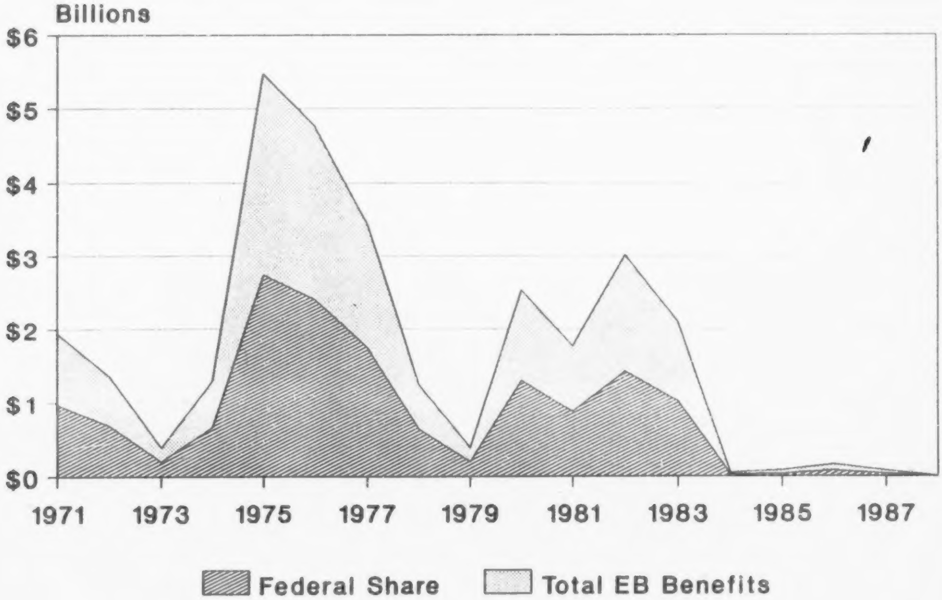
Source: U.S. Department of Labor.

EXTENDED BENEFITS

The Federal-State extended benefits program provides one-half of a claimant's total State benefits up to 13 weeks in States with an activated program, for a combined maximum of 39 weeks of regular and extended benefits. Weekly benefit amounts are identical to the regular State UC benefits for each claimant, and Federal funds pay half the cost. The program activates in a State under two conditions: (1) if the State's 13-week average insured unemployment rate (IUR) in the most recent 13 weeks is at least 120 percent of the average of its 13-week IUR's in the last 2 years for the same 13-week calendar period and its current 13-week average IUR is at least 5.0 percent; or (2) at State option, if its current 13-week average IUR is at least 6.0 percent. All but 13 State programs have adopted the second, optional condition. The 13-week average IUR is calculated from the ratio of the average number of insured unemployed persons under the regular State programs in the last 13 weeks to the average covered employment in the first 4 of the last 6 completed calendar quarters. Table 10 shows the 13-week IUR's by State for the first week in each January from 1986 through 1991. As indicated in the last column, no State had an activated EB program in the first week of January 1991.

Chart 7 graphs expenditures for EB in constant dollars from 1971 to 1988. The program's real spending declined significantly during the 1981–82 recession relative to spending in the 1973–75 recession, despite the considerably higher unemployment rate during the 1981–82 recession.

CHART 7. FEDERAL-STATE EXTENDED BENEFITS IN BILLIONS OF CONSTANT 1988 DOLLARS, 1971–88



Source: Chart prepared by CRS based on data from DoL.

BENEFIT EXHAUSTION

Due to the limited duration of UC benefits, some individuals exhaust their benefits. For the regular State programs, 2.3 million individuals exhausted their benefits in 1990, or about 30 percent of claimants who began receiving UC during the 12 months ending June 30, 1990. These exhaustions raise the question of whether policies are needed to reduce the exhaustion rate or ameliorate financial hardships caused by the cessation of benefits.

A study of exhaustees was completed in September 1990 by Mathematica Policy Research, Inc., under contract to the U.S. Department of Labor.[2] The purpose of this study was to examine the characteristics and behavior of exhaustees and nonexhaustees and to explore the implications of this information.

The UC exhaustees study was designed to provide nationally representative estimates of the characteristics of exhaustees and nonexhaustees. Sample selection was a two-stage process in which 20 States were selected randomly in the first stage with a probability proportional to their number of exhaustees. Simple random samples of recipients were then selected in the second stage, and subsamples of exhaustees and nonexhaustees were interviewed in each State. The sizes of these subsamples were adjusted to obtain nationally representative samples of exhaustees and nonexhaustees. The samples were chosen from individuals who began collecting benefits during the period October 1987 through September 1988. Overall, 1,920 exhaustees and 1,009 nonexhaustees were interviewed.

The analysis of factors underlying exhaustion indicated that:

—A major distinction between exhaustees and nonexhaustees pertained to their expectation about recall by their last employer. Individuals who expected to be recalled and had a definite date of recall were largely nonexhaustees, since they were generally on temporary layoffs; individuals with no recall expectations were more likely to be exhaustees. Individuals who expected to be recalled but had no recall date were more likely to be exhaustees than were individuals with definite recall dates but were less likely to be exhaustees than were individuals with no recall expectations.

—Differences in recall probabilities accounted for many of the differences in pre-UC job characteristics between exhaustees and nonexhaustees, such as the fact that exhaustees were less likely to come from manufacturing industries.

—Higher UC wage replacement rates increased the probability of exhaustion for workers who did not expect to be recalled. Wage replacement rates did not significantly affect the probability of exhaustion for workers who expected to be recalled.

—Longer potential durations lowered the probability of exhaustion. The effect of longer potential durations on reducing the probability of exhaustion was greater for workers who expected to be recalled.

---

[2] Corson, Walter and Dynarski, Mark. A Study of Unemployment Insurance Recipients and Exhaustees: Findings from a National Survey. U.S. Department of Labor, Unemployment Insurance Service. Occasional Paper 90-3. September 1990.

—Workers who expected to be recalled, but were not, experienced much longer unemployment spells than did workers who expected to be recalled and were recalled. The average completed spell of unemployment was 10 weeks for UC recipients who had definite recall dates when they were laid off and who were recalled and 26 weeks for UC recipients who had definite recall dates when they were laid off but who found new employment.

—Twenty-five percent of workers who exhausted their UC benefits were reemployed within 4 weeks after exhaustion, but 60 percent still were unemployed 10 weeks after exhaustion.

—Among workers who did not expect to be recalled, older workers, female workers with working spouses, workers with greater job seniority, union members, and workers in areas that exhibit high unemployment had longer unemployment spells. These factors generally did not have significant effects on the lengths of unemployment spells for workers who expected to be recalled.

—Exhaustees were more likely than nonexhaustees to look for work at the start of the UC claim. This difference was due primarily to the difference in recall expectations. Among individuals with no recall expectations, the proportions of exhaustees and nonexhaustees who looked for work were identical (84 percent). Among individuals who looked for work, the intensity of job search was as high for exhaustees as it was for nonexhaustees, or higher.

—A sizeable proportion of exhaustees (18 percent) reported not looking for work at the start of the UC claim. Some of these individuals were job-attached, but they were not the majority. Fully 60 percent (11 percent of all exhaustees) gave reasons for not looking for work that would classify them as being out of the labor force.

—A larger proportion of exhaustees (37 percent) than of nonexhaustees (14 percent) suffered a reduction of 25 percent or more in weekly wages on the first post-UC job relative to the pre-UC job. Overall, the mean weekly wages of exhaustees declined by 16 percent, from $415 to $347, while the mean weekly wages of nonexhaustees remained stable at just over $400 per week. A reduction in hours worked by exhaustees (from 44 to 39 hours) explained about two-thirds of the reduction in mean weekly wages.

—At the start of the UC claim, 64 percent of exhaustees received reemployment services (other than training) from the Employment Service, and 8 percent received services from another source. Rates of reemployment service receipt were lower for nonexhaustees, due primarily to their greater job attachment. The rates of service receipt from the Employment Service were similar for exhaustees and nonexhaustees who had no recall expectations.

—Few exhaustees and nonexhaustees received pensions or social security benefits. Even fewer received cash or in-kind public assistance. However, the rate of public assistance receipt was higher for exhaustees than for nonexhaustees. The rate of public assistance receipt also increased following the exhaustion of benefits.

Finally, the authors reached three general conclusions about policy: [3]

—A large proportion of UI recipients were job-attached, in the sense that they expected to be recalled to their previous jobs. The unemployment spells of job-attached workers were considerably shorter than the unemployment spells of workers who suffered permanent job losses, and few job-attached workers exhausted their UI benefits. The practice of exempting job-attached workers from administrative work-search requirements is sensible under these circumstances. Workers who were not job-attached—in particular, workers who were dislocated from their previous jobs or who had low skill levels—were likely to experience long unemployment spells, and a significant proportion of these workers exhausted their UI benefits. For this group, administrative work-search requirements are sensible. Targeting reemployment services to this group may also be a reasonable strategy for reducing periods of joblessness. These services might include enhanced job-search assistance and referrals to JTPA if job training is necessary.

—The work disincentive effect did not appear to be a dominating factor in explaining the exhaustion of UI benefits. Most workers who exhausted their UI benefits were still unemployed more than a month after receiving their final UI payment, and a majority were still unemployed two months after receiving their final UI payment. Moreover, workers who found jobs after exhausting their UI benefits were generally receiving lower wages than on their pre-UI jobs. Neither result is consistent with strong disincentive effects. Under these circumstances, extending the potential duration of UI benefits may reduce the financial hardships of exhaustion considerably, while creating only mild disincentive effects for some workers.

—State exhaustion rate trigger mechanisms would not be clearly superior to the State Insured Unemployed Rate (IUR) trigger in targeting extended benefits to areas with high cyclical unemployment, and substate trigger mechanisms for extended benefits would do a poor job of targeting extended benefits to local areas with high structural unemployment.

---

[3] Corson, Walter and Dynarski, Mark. Unemployment Insurance Recipients and Exhaustees: Findings from a National Survey Summary Report. Mathematica Policy Research, Inc. MPR Reference No.: 7805. January 1991.

TABLE 10.—STATE EXTENDED BENEFIT INDICATORS FOR THE FIRST WEEK IN JANUARY 1986 THROUGH 1991 AND EB BENEFIT WEEKS FOR JANUARY 1991

	13-week insured unemployment rate						1991 as percent of prior 2 years	EB weeks
	1986	1987	1988	1989	1990	1991		
Alabama	3.16	3.25	2.23	2.27	2.25	2.65	117	0
Alaska	6.81	7.45	5.89	5.26	5.02	5.65	109	0
Arizona	1.61	1.86	1.59	NA	1.44	1.76	119	0
Arkansas [1]	3.82	3.99	3.29	3.17	3.15	3.53	111	0
California	3.49	3.25	2.61	2.61	2.52	3.41	132	0
Colorado	2.12	2.52	1.98	1.68	1.45	1.46	93	0
Connecticut	1.61	1.40	1.04	1.30	1.97	3.04	186	0
Delaware [1]	1.26	1.20	.76	1.10	1.27	1.68	141	0
Dist. of Columbia	1.99	1.97	1.69	1.59	1.57	2.10	132	0
Florida [1]	1.35	1.23	1.00	1.03	1.14	1.71	158	0
Georgia [1]	1.65	1.71	1.27	1.38	1.46	2.04	143	0
Hawaii	2.21	1.86	1.54	1.27	0.98	1.11	98	0
Idaho	4.27	4.33	3.33	3.14	2.76	3.15	106	0
Illinois	2.94	2.66	2.15	1.89	2.09	2.49	125	0
Indiana	2.08	2.06	1.36	1.10	1.25	1.52	129	0
Iowa [1]	2.91	2.82	1.69	1.57	1.64	1.94	120	0
Kansas	2.49	2.51	2.00	1.94	2.00	2.00	101	0
Kentucky [1]	3.19	2.68	2.02	1.98	2.22	2.78	132	0
Louisiana	4.42	5.32	3.13	2.58	2.12	1.98	84	0
Maine	2.95	2.20	1.67	1.66	2.42	3.91	189	0
Maryland	2.09	1.76	1.40	1.30	1.36	2.27	162	0
Massachusetts [1]	2.28	1.95	1.55	1.88	3.18	3.80	150	0
Michigan	2.90	3.12	3.17	2.60	3.03	3.35	119	0
Minnesota	2.61	2.21	1.87	1.77	1.87	2.00	109	0
Mississippi	3.27	3.85	2.48	2.55	2.58	2.80	109	0
Missouri	2.33	2.49	2.07	2.01	2.18	2.67	134	0
Montana	3.73	3.44	2.79	2.62	2.54	2.89	112	0
Nebraska	2.39	1.90	1.37	1.14	1.06	1.07	97	0
Nevada	2.88	2.56	2.08	1.83	1.75	2.56	143	0
New Hampshire [1]	.86	.71	.42	.55	1.40	2.33	240	0
New Jersey	2.53	2.09	1.74	1.85	2.35	3.12	148	0
New Mexico	2.64	3.31	2.30	2.06	1.92	1.94	96	0
New York	2.52	2.28	1.92	1.88	2.56	2.93	150	0
North Carolina	2.02	1.74	1.20	1.39	1.60	2.65	177	0
North Dakota [1]	2.84	2.70	2.15	1.91	1.57	1.56	89	0
Ohio	2.95	2.65	2.11	1.79	2.02	2.30	121	0
Oklahoma	2.36	2.90	1.87	1.57	1.47	1.64	107	0
Oregon	4.51	3.97	3.17	2.78	2.78	3.71	133	0
Pennsylvania	3.80	3.29	2.38	2.37	2.69	3.34	132	0
Puerto Rico	6.69	5.46	4.64	4.18	5.34	5.49	115	0

TABLE 10.—STATE EXTENDED BENEFIT INDICATORS FOR THE FIRST WEEK IN JANUARY 1986 THROUGH 1991 AND EB BENEFIT WEEKS FOR JANUARY 1991—Continued

	13-week insured unemployment rate						1991 as percent of prior 2 years	EB weeks
	1986	1987	1988	1989	1990	1991		
Rhode Island	2.99	2.55	2.04	2.43	3.20	4.43	155	0
South Carolina	2.59	2.10	1.50	1.69	1.94	2.48	136	0
South Dakota [1]	1.54	1.18	1.20	.95	0.89	0.77	83	0
Tennessee	2.61	2.34	1.95	2.07	2.13	2.85	131	0
Texas	1.72	2.78	1.91	1.73	1.70	1.73	100	0
Utah [1]	2.27	2.39	1.62	1.45	1.15	1.30	100	0
Vermont	2.66	2.05	1.40	1.59	2.31	3.59	184	0
Virginia	1.06	.94	.75	.86	0.87	1.39	159	0
Virgin Islands	2.70	1.50	.78	1.33	3.79	0.66	25	0
Washington [1]	4.30	3.92	3.45	3.26	3.15	3.54	110	0
West Virginia	4.19	3.79	2.78	2.54	2.63	3.06	118	0
Wisconsin	3.34	2.91	2.24	2.09	2.17	2.48	116	0
Wyoming [1]	2.48	3.98	2.28	2.10	1.69	1.63	85	0

[1] State does not use optional trigger of IUR in excess of 6 percent.

NA—Not available.

Source: U.S. Department of Labor.

Supplemental Benefits

The extended benefits (EB) program was enacted to provide unemployment benefits to workers who had exhausted their regular benefits during periods of high unemployment. Before enactment of a permanent EB program, Congress authorized two temporary programs. First, a voluntary program was authorized by the Temporary Unemployment Compensation (TUC) Act of 1958 (P.L. 85-441). TUC was signed into law on June 4, 1958; it expired on April 10, 1959 (June 30, 1959, for Federal employees and veterans). TUC was established in response to the 1957-58 recession. It offered States interest-free loans if they increased the duration of benefits to UI recipients by 50 percent (up to a maximum of 13 weeks) after they had exhausted their regular benefits. A total of 17 States participated, while 5 other States enacted their own EB programs. Between June 1958 and July 1959 slightly over 2 million claimants received benefits totalling $600 million under TUC.

The second temporary EB program was authorized by the Temporary Extended Unemployment Compensation (TEUC) Act of 1961 (P.L. 87-6). TEUC was enacted on March 24, 1961; it expired on June 30, 1962. The program was financed through the Unemployment Trust Fund by a temporary increase in the net Federal unemployment tax. All States were required to participate. UI recipients who had exhausted their regular benefits could receive up to 50 percent of their regular benefits for up to 13 weeks, provided that the combined total duration of regular and extended benefits did not exceed 39 weeks. A total of 2.8 million claimants received benefits totaling $817 million during the 15 months of this program.

The Federal-State Extended Unemployment Compensation Act of 1970 (P.L. 91-373) authorized a permanent mechanism for providing extended benefits. Under the original program, UI recipients who had exhausted their regular benefits could receive EB if: (1) the national seasonally adjusted insured unemployment rate reached at least 4.5 percent for 3 consecutive months; or (2) if their State's insured unemployment averaged at least 4 percent for 13 consecutive weeks and was at least 120 percent higher than the average insured unemployment rate for the corresponding 13 weeks during the preceding 2 years. As with TEUC, UI recipients who exhausted their regular benefits receive 50 percent of their regular benefits for up to 13 weeks of EB, provided that the total duration did not exceed 39 weeks. The present EB rules were adopted in the Omnibus Budget Reconciliation Act (OBRA) of 1981 (P.L. 97-35).

On three occasions temporary programs have provided supplemental benefits to UI recipients who had exhausted both their regular and extended benefits during periods of severe unemployment.

The Emergency Unemployment Compensation Act of 1971 (P.L. 92-224) was enacted on December 29, 1971, and was originally scheduled to expire on September 30, 1972. This program was financed by the Federal Government through the Extended Unemployment Compensation Account (EUCA), from which non-interest-bearing repayable advances were made available to the States. A State became eligible when its insured unemployment rate was at least 6.5 percent, unless it failed to meet a requirement that the average of the current 13-week insured unemployment rate be at least 120 percent of the average of the rates for the same 13-week periods for the last 2 years. UI recipients who exhausted their regular and extended benefits were eligible to receive benefits for up to half of the duration of their regular benefits or 13 weeks, whichever was less. P.L. 92-329 extended this act for 6 months, until it expired on March 31, 1973.

The Emergency Unemployment Compensation Act of 1974 (P.L. 93-572) was enacted on December 31, 1974, and created the Federal Supplemental Benefits (FSB) program. FSB was authorized in response to the 1974-75 recession. Initially, funds for the program came from non-interest-bearing repayable advances from the general fund, which Congress expected the Unemployment Trust Fund to repay eventually out of EUCA after the recession. UI recipients who exhausted their regular and extended benefits could receive up to 13 weeks of FSB. States became eligible if they met either the national or State insured unemployment rates specified in the Federal-State Unemployment Compensation Act of 1970 for EB eligibility. This act was extended 3 times.

The Tax Reduction Act of 1975 (P.L. 94-12) doubled the potential duration of FSB to 26 weeks, allowing a UI recipient to receive benefits under the regular, extended, and FSB programs for a potential duration of 65 weeks. These additional benefits were financed by the Federal Government; they were to expire on January 1, 1976. The Emergency Compensation and Special Unemployment Assistance Extension Act of 1975 (P.L. 94-45) extended FSB to March 31, 1977. Among other provisions, this law abolished the national trigger for State FSB eligibility. The Emergency Unemployment Compensation Extension Act of 1977 (P.L. 95-19) reduced FSB to a potential duration of 13 weeks. The Act provided that, after April 1, 1977, FSB would be financed through non-repayable advances from Federal general revenue. It also extended FSB to October 31, 1977, when the program finally expired.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-248) established the Federal Supplemental Compensation (FSC) program. TEFRA was enacted on September 3, 1982, and FSC was scheduled to expire on March 31, 1983. The program provided benefits to UI recipients who had exhausted their regular and extended benefits on or after June 1, 1982, for up to 6, 8, or 10 weeks of benefits. FSC claimants received the same weekly sums as under the regular Federal-State UI program. The FSC program was extended and modified several times.

The Surface Transportation Assistance Act of 1982 (P.L. 97-424) was enacted on January 6, 1983. The act provided that the duration of FSC benefits would be 16, 14, 12, 10, or 8 weeks, depending on conditions within a State. The expiration date of March 31, 1983 was left unchanged. P.L. 98-13, which was enacted on March 29, 1983, continued the program past the expiration date pending completion of the Social Security Amendments of 1983, which contained a 6-month extension. That measure, enacted on April 20, 1983 (P.L. 98-21), extended FSC retroactively from April 1, 1983 to September 30, 1983. This act provided for basic FSC benefits for 14, 12, 10, or 8 weeks, depending on the unemployment conditions within the State. It also provided additional FSC benefits of 10, 8, or 6 weeks to individuals who exhausted their basic FSC benefits on or before April 1, 1983. Additional FSC benefits were equal to three-fourths of the basic FSC benefits payable in the State.

FSC was extended three more times. P.L. 98-118, enacted on October 11, 1983, extended FSC to October 18, 1983. The Federal Supplemental Compensation Amendments of 1983 (P.L. 98-135), enacted on October 24, 1983, extended FSC until March 31, 1985. This legislation provided basic FSC benefits for up to 14, 12, 10, or 8 weeks and provided additional FSC benefits for up to 5, 4, or 2 weeks, depending on the unemployment conditions within a State. P.L. 99-15, enacted on April 4, 1985, extended the FSC program until June 30, 1985, when it finally expired.

No supplemental benefit program was in effect as of March 1991.

HYPOTHETICAL WEEKLY BENEFIT AMOUNTS FOR VARIOUS WORKERS IN THE REGULAR STATE PROGRAMS

The following table (table 11) illustrates the amount of benefits various full-year workers can receive in regular State programs. All of the benefit amounts are for January 1991. Column A of the table is for a full-time worker earning the minimum wage; column B is for a worker earning $6 per hour, while column C shows benefit amounts for a worker earning $9 per hour. Column D is a part-time worker earning the minimum wage and working 20 hours per week. The weekly benefit amount for the minimum wage worker varies from $61 to $145. The maximum amount a worker can receive in these examples (column C) in each State varies considerably, from $120 to $248 per week.

TABLE 11.—WEEKLY BENEFIT AMOUNT FOR VARIOUS FULL-YEAR WORKERS IN SELECTED STATES IN JANUARY 1991

	Hypothetical worker [1]			
	A	B	C	D
Alabama	150	150	150	92
Alaska	85	134	232	42
Arizona	106	125	165	70
Arkansas	88	120	180	44
California	82	105	142	46
Colorado	101	143	179	50
Connecticut	95	130	210	52
Delaware	96	135	203	48
District of Columbia	101	135	213	53
Florida	85	120	180	42
Georgia	88	124	185	44
Hawaii	89	125	188	45
Idaho	85	120	180	0
Illinois	98	138	231	58
Indiana	95	113	147	47
Iowa	101	142	210	50
Kansas	93	132	198	55
Kentucky	105	148	199	50
Louisiana	77	109	164	38
Maine	110	151	218	60
Maryland	93	130	211	47
Massachusetts	85	120	230	43
Michigan	NA	NA	NA	NA
Minnesota	85	120	180	42
Mississippi	85	120	145	42
Missouri	99	140	170	49
Montana	83	117	176	48
Nebraska	92	128	144	48
Nevada	88	124	187	44
New Hampshire	102	123	144	52
New Jersey	109	154	248	0
New Mexico	85	120	177	42
New York	85	120	180	43
North Carolina	85	120	180	42
North Dakota	85	120	180	0
Ohio	102	120	180	0
Oklahoma	88	124	187	44
Oregon	110	156	234	57
Pennsylvania	95	132	197	52
Puerto Rico	85	120	120	43

TABLE 11.—WEEKLY BENEFIT AMOUNT FOR VARIOUS FULL-YEAR WORKERS IN SELECTED STATES IN JANUARY 1991—Continued

	Hypothetical worker [1]			
	A	B	C	D
Rhode Island	107	144	236	56
South Carolina	85	120	175	42
South Dakota	85	120	140	42
Tennessee	146	165	165	81
Texas	89	125	188	45
Utah	85	120	180	43
Vermont	98	138	182	49
Virginia	88	124	187	0
Virgin Islands	89	125	163	45
Washington	176	246	246	88
West Virginia	93	131	198	46
Wisconsin	88	124	187	44
Wyoming	88	124	187	44

[1] Hypothetical workers:
A. $4.25/hr. wage; 40 hrs./wk.; 52 wks./yr.; nonworking spouse; no children.
B. $6.00/hr. wage; 40 hrs./wk.; 52 wks./yr.; nonworking spouse; no children.
C. $9.00/hr. wage; 40 hrs./wk.; 52 wks./yr.; nonworking spouse; 2 children.
D. $4.25/hr. wage; 20 hrs./wk.; 52 wks./yr.; nonworking spouse; no children.

NA—Means not available.

Source: U.S. Department of Labor.

RECENT MAJOR LEGISLATION

Major Federal laws passed by Congress since 1970 and some of their provisions are:

(1) The Employment Security Amendments of 1970 (Public Law 91-373) expanded FUTA coverage primarily to small businesses, nonprofit organizations, and higher educational institutions. It also raised the taxable wage base from the original $3,000 to $4,200 in 1972; increased the minimum, net Federal unemployent tax rate from 0.4 to 0.5 percent in 1970; and created the Federal-State extended benefits program.

(2) The Unemployment Compensation Amendments of 1976 (Public Law 94-566), extended FUTA coverage primarily to State-local government workers and certain agricultural and domestic labor. It also raised the taxable wage base to $6,000 in 1978 and temporarily increased the minimum, net Federal unemployment tax rate from 0.5 to 0.7 percent in 1977. It established the offset of retirement benefits against unemployment benefits.

(3) The Revenue Act of 1978 (Public Law 95-600) subjected unemployment benefits to Federal income taxes for the first time.

(4) The Omnibus Budget Reconciliation Act of 1980 (Public Law 96-499) provided for a denial of extended benefits to claimants under certain circumstances who have rejected a minimum wage job.

(5) The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) imposed interest charges up to 10 percent per annum under certain conditions on loans obtained by State UC programs after April 1, 1982. It also reduced the extended benefits program by an estimated $3 to $4 billion in fiscal year 1983. The primary changes that resulted in this reduction were: (A) elimination of the national trigger under the extended benefits program; (B) raising the State trigger to 5 percent, and 120 percent, or 6 percent; and (C) excluding claims for extended compensation from the calculation of the insured unemployment rate used for the extended benefit trigger.

(6) The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) increased the taxable wage base from $6,000 to $7,000 and raised the minimum, net Federal unemployment tax rate to 0.8 percent in 1983. It also raised the gross tax and credit rates in 1985 to 6.2 and 5.4 percent, respectively. This leaves the minimum, net Federal rate unaffected but raises the maximum, potential, net tax rate in States with delinquent loans from 3.4 to 6.2 percent. The Act also created the temporary Federal supplemental compensation program, which authorized 6 to 10 additional weeks of benefits through March 31, 1983. This act also rounded UC benefits to the lowest dollar, extended the Reed Act, modified the treatment of school employees, and reduced the thresholds for taxation of unemployment compensation to $12,000 for single filers and $18,000 for married couples filing jointly.

(7) The Surface Transportation Assistance Act (Public Law 97-424), passed in a lame-duck session of Congress, added 2 to 6 weeks to the Federal Supplemental Compensation program for a combined maximum in that program of 8 to 16 weeks.

(8) The Social Security Amendments of 1983 (Public Law 98-21) extended the Federal supplemental compensation program through September 30, 1983, providing a maximum of 8 to 14 weeks of benefits. It also established conditions under which States could defer the payment of interest on loans from the Federal Unemployment Account and qualify for reduced FUTA credit reductions.

(9) The Federal Supplemental Compensation Amendments of 1983 (Public Law 98-135) extended the Federal Supplemental Compensation program through March 31, 1985, providing a maximum of 8 to 14 weeks of benefits.

(10) The Tax Reform Act of 1986 (Public Law 99-514) made all unemployment compensation subject to taxation under the Federal personal income tax.

(11) The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) extended the 0.2 percent FUTA surtax for 3 years through 1990.

(12) The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) extended the 0.2 percent FUTA surtax for 5 years through 1995.

APPENDIX F. STATISTICAL DATA ON UNEMPLOYMENT, EMPLOYMENT AND EARNINGS, AND THE UNEMPLOYMENT COMPENSATION PROGRAM

The following tables and charts provide statistical data on unemployment and labor force projections, dislocated workers, historical information on the unemployment compensation program, earnings, and the changing earnings distribution of jobs. The tables in the appendix are organized as follows:

Table(s):	Topic
1–4	Unemployment rates and duration.
5–6	Family incomes of unemployment insurance recipients.
7	Unemployment rates by State.
8–10	Employment and labor force projections.
11–16	Dislocated workers.
17–28	Historical information on the unemployment compensation program.
29–32	Projections of unemployment compensation trust fund balances.
33	Labor force statistics.
34–38	Average annual earnings and earnings distribution.
39–41	The Federal minimum wage.

UNEMPLOYMENT DATA

TABLE 1.—MONTHLY DATA FOR CIVILIAN UNEMPLOYMENT RATE AND INSURED UNEMPLOYMENT RATE SINCE 1970

Year	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Avg.
Civilian Unemployment Rate—Total (Seasonally Adjusted)													
1970	3.9	4.2	4.4	4.6	4.8	4.9	5.0	5.1	5.4	5.5	5.9	6.1	4.9
1971	5.9	5.9	6.0	5.9	5.9	5.9	6.0	6.1	6.0	5.8	6.0	6.0	5.9
1972	5.8	5.7	5.8	5.7	5.7	5.7	5.6	5.6	5.5	5.6	5.3	5.2	5.6
1973	4.9	5.0	4.9	5.0	4.9	4.9	4.8	4.8	4.8	4.6	4.8	4.9	4.9
1974	5.1	5.2	5.1	5.1	5.1	5.4	5.5	5.5	5.9	6.0	6.6	7.2	5.6
1975	8.1	8.1	8.6	8.8	9.0	8.8	8.6	8.4	8.4	8.4	8.3	8.2	8.5
1976	7.9	7.7	7.6	7.7	7.4	7.6	7.8	7.8	7.6	7.7	7.8	7.8	7.7
1977	7.5	7.6	7.4	7.2	7.0	7.2	6.9	6.9	7.0	6.8	6.8	6.4	7.1
1978	6.4	6.3	6.3	6.1	6.0	5.9	6.2	5.9	6.0	5.8	5.9	6.0	6.1
1979	5.9	5.9	5.8	5.8	5.6	5.7	5.7	6.0	5.9	6.0	5.9	6.0	5.8
1980	6.3	6.3	6.3	6.9	7.5	7.6	7.8	7.7	7.5	7.5	7.5	7.2	7.1
1981	7.5	7.4	7.4	7.2	7.5	7.5	7.2	7.4	7.6	7.9	8.3	8.5	7.6
1982	8.6	8.9	9.0	9.3	9.4	9.6	9.8	9.8	10.1	10.4	10.7	10.7	9.7
1983	10.4	10.4	10.3	10.2	10.2	10.1	9.4	9.4	9.2	8.8	8.4	8.2	9.6
1984	8.0	7.8	7.8	7.8	7.5	7.2	7.5	7.5	7.4	7.3	7.1	7.2	7.5
1985	7.4	7.3	7.2	7.3	7.2	7.3	7.3	7.1	7.1	7.1	7.0	7.0	7.2
1986	6.8	7.2	7.2	7.1	7.2	7.1	7.0	6.8	7.0	6.9	6.9	6.7	7.0
1987	6.7	6.6	6.5	6.3	6.3	6.1	6.0	6.0	5.9	6.0	5.9	5.8	6.2
1988	5.8	5.7	5.6	5.4	5.6	5.3	5.4	5.6	5.4	5.3	5.4	5.3	5.5
1989	5.4	5.2	5.1	5.2	5.2	5.4	5.2	5.2	5.3	5.3	5.3	5.3	5.3
1990	5.3	5.3	5.3	5.4	5.3	5.3	5.5	5.6	5.7	5.7	5.9	6.1	5.5

Insured Unemployment Rate Under State Programs (Seasonally Adjusted)

1970	2.5	2.7	2.8	3.2	3.5	3.6	3.6	3.7	4.0	4.4	4.4	4.0	3.4
1971	3.9	3.9	4.0	4.1	4.1	4.1	3.9	4.2	4.3	4.2	4.1	4.0	4.1
1972	3.7	3.7	3.6	3.6	3.6	3.5	3.7	3.4	3.4	3.2	3.2	3.2	3.5
1973	2.9	2.8	2.8	2.6	2.7	2.7	2.6	2.8	2.7	2.7	2.7	2.9	2.7
1974	3.1	3.2	3.3	3.2	3.2	3.3	3.3	3.4	3.5	3.7	4.4	5.0	3.5
1975	5.6	5.8	6.4	6.7	6.9	6.8	6.1	5.9	5.8	5.6	5.3	4.9	6.0
1976	4.6	4.3	4.3	4.4	4.5	4.5	4.6	4.6	4.7	4.7	4.7	4.4	4.6
1977	4.3	4.2	4.1	4.0	3.9	3.9	3.8	3.8	3.8	3.8	3.8	3.7	3.9
1978	3.5	3.7	3.6	3.3	3.2	3.2	3.3	3.4	3.2	3.1	2.9	3.2	3.3
1979	3.1	3.2	3.1	3.0	2.8	2.8	2.8	3.0	2.9	3.0	3.1	3.2	2.9
1980	3.3	3.3	3.4	3.7	4.2	4.4	4.4	4.3	4.2	4.0	3.8	3.6	3.9
1981	3.5	3.5	3.4	3.3	3.3	3.3	3.3	3.3	3.4	3.6	3.9	4.0	3.5
1982	4.2	4.0	4.3	4.6	4.5	4.7	4.7	4.7	5.0	5.2	5.3	4.8	4.6
1983	4.5	4.7	4.5	4.4	4.2	3.9	3.7	3.5	3.4	3.3	3.3	3.2	3.9
1984	2.9	2.8	2.9	2.8	2.8	2.7	2.7	2.7	2.7	2.8	2.7	3.0	2.8
1985	2.8	3.0	3.0	2.9	2.8	2.8	2.8	2.8	2.8	2.6	2.8	2.9	2.8
1986	2.7	2.8	2.9	2.8	2.8	2.9	2.8	2.9	2.8	2.8	2.8	2.7	2.8
1987	2.6	2.6	2.6	2.5	2.4	2.4	2.4	2.3	2.2	2.1	2.1	2.2	2.4
1988	2.3	2.3	2.2	2.1	2.1	2.1	2.1	2.1	2.0	2.0	2.0	2.0	2.1
1989	2.1	2.1	2.1	2.1	2.0	2.1	2.2	2.1	2.2	2.2	2.2	2.3	2.1
1990	2.3	2.3	2.3	2.3	2.3	2.3	2.4	2.4	2.5	2.6	2.8	2.9	—

TABLE 2.—STATE INSURED UNEMPLOYMENT RATES FOR CALENDAR YEARS 1983–89 AND RATES BY CALENDAR QUARTER FOR 1990 UNDER THE UNEMPLOYMENT COMPENSATION PROGRAM

[Percent]

	1983	1984	1985	1986	1987	1988	1989	1990			
								I	II	III	IV
Alabama	4.6	3.5	3.3	3.2	2.8	2.2	2.5	2.7	2.1	2.2	2.5
Alaska	6.7	6.2	7.1	8.0	6.6	5.6	6.3	7.5	5.2	3.6	5.5
Arizona	3.2	1.9	1.8	2.0	2.0	1.5	1.9	1.8	1.8	2.0	1.8
Arkansas	4.6	3.5	3.7	3.6	3.4	3.2	3.3	3.8	2.8	2.6	3.3
California	4.7	3.4	3.6	3.5	3.0	2.7	2.9	3.1	2.8	2.8	3.3
Colorado	3.1	2.1	2.3	2.5	2.4	2.0	2.2	1.9	1.5	1.3	1.4
Connecticut	2.9	1.8	1.8	1.6	1.4	1.3	1.3	2.9	2.6	2.7	2.9
Delaware	2.6	2.0	1.6	2.0	1.2	1.4	1.3	1.8	1.1	1.2	1.6
District of Columbia	3.2	2.5	2.1	2.1	2.0	1.8	1.9	1.8	1.7	2.0	2.1
Florida	2.1	1.4	1.4	1.6	1.2	1.1	1.1	1.3	1.3	1.7	1.7
Georgia	2.5	1.8	1.8	1.8	1.6	1.4	1.5	1.8	1.5	1.6	1.9
Hawaii	3.4	2.9	2.5	2.1	1.7	1.5	1.6	1.4	1.1	1.1	1.1
Idaho	5.6	4.2	4.5	4.8	4.2	3.6	3.9	4.6	3.0	2.5	2.8
Illinois	4.8	3.1	3.2	2.9	2.6	2.2	2.5	2.9	2.2	2.1	2.4
Indiana	3.7	2.5	2.3	2.1	1.7	1.4	1.6	1.9	1.2	1.0	1.4
Iowa	3.7	2.7	3.0	2.9	2.1	1.7	2.0	2.5	1.5	1.2	1.8
Kansas	3.1	2.2	2.4	2.7	2.4	2.1	2.2	2.3	1.7	1.7	1.9
Kentucky	4.9	3.3	3.3	3.2	2.4	2.3	2.4	2.9	2.0	1.9	2.4
Louisiana	5.2	3.9	4.4	5.3	4.1	3.0	3.7	2.4	1.9	1.8	1.9
Maine	4.5	3.7	3.5	2.9	2.3	1.9	2.1	4.2	3.1	2.5	3.6
Maryland	3.5	2.3	2.2	2.1	1.7	1.5	1.6	2.1	1.6	1.7	2.2
Massachusetts	3.2	2.3	2.4	2.5	1.8	2.0	1.9	4.3	3.6	3.5	3.6
Michigan	4.7	3.4	3.2	3.4	3.5	3.3	3.4	4.6	2.7	2.5	3.2
Minnesota	3.1	2.3	2.6	2.5	2.1	2.0	2.0	3.0	1.9	1.5	1.8
Mississippi	5.0	3.7	3.7	4.0	3.2	2.7	3.0	3.2	2.4	2.4	2.6
Missouri	3.5	2.5	2.6	2.6	2.4	2.2	2.3	2.9	2.0	2.1	2.5
Montana	4.8	4.1	3.9	3.9	3.4	3.0	3.2	4.1	2.6	2.0	2.7
Nebraska	2.7	2.0	2.3	2.1	1.8	1.4	1.6	1.5	0.9	0.9	1.0
Nevada	4.0	2.9	2.8	2.8	2.4	2.0	2.2	2.3	1.9	2.0	2.5
New Hampshire	2.2	1.5	1.0	0.8	0.6	0.6	0.6	2.4	2.1	2.0	2.2
New Jersey	3.9	3.1	2.9	2.6	2.4	2.1	2.1	3.2	2.7	2.9	3.0
New Mexico	4.0	2.9	2.8	3.4	2.9	2.4	2.7	2.4	2.0	1.8	1.9
New York	3.5	3.0	2.8	2.5	2.2	2.1	2.2	3.1	2.6	2.6	2.8
North Carolina	3.1	2.2	2.3	1.9	1.6	1.4	1.5	2.0	1.6	1.6	2.4
North Dakota	3.5	3.0	3.1	2.9	2.6	2.3	2.5	3.0	1.4	1.1	1.4
Ohio	4.2	3.0	3.0	2.8	2.4	2.1	2.3	2.8	1.8	1.7	2.2
Oklahoma	3.0	2.0	2.4	3.3	2.3	1.8	2.1	1.8	1.5	1.5	1.6

TABLE 2.—STATE INSURED UNEMPLOYMENT RATES FOR CALENDAR YEARS 1983–89 AND RATES BY CALENDAR QUARTER FOR 1990 UNDER THE UNEMPLOYMENT COMPENSATION PROGRAM—Continued

[Percent]

	1983	1984	1985	1986	1987	1988	1989	1990			
								I	II	III	IV
Oregon	5.5	4.3	4.6	4.9	3.5	3.1	3.4	3.8	2.9	2.7	3.5
Pennsylvania	5.9	4.2	4.0	3.6	2.9	2.6	2.8	3.6	2.8	2.7	3.2
Puerto Rico	7.2	6.3	7.1	5.7	4.9	4.2	4.6	4.8	4.7	5.3	5.5
Rhode Island	4.7	3.5	3.6	3.1	2.7	2.7	2.7	5.1	4.1	4.2	4.1
South Carolina	3.6	2.5	2.9	2.1	1.7	1.6	1.7	2.0	1.5	1.8	2.2
South Dakota	1.7	1.2	1.6	1.4	1.3	1.2	1.2	1.4	0.7	0.6	0.7
Tennessee	3.6	2.5	2.7	2.4	2.1	2.1	2.1	3.0	2.2	2.2	2.6
Texas	2.4	1.5	1.6	2.5	2.2	1.8	2.1	2.0	1.6	1.5	1.7
Utah	4.0	2.7	2.4	2.5	2.2	1.7	2.0	1.8	1.2	1.0	1.2
Vermont	4.3	3.2	3.1	2.5	2.0	1.8	1.9	3.8	3.3	2.4	3.3
Virginia	1.8	1.2	1.2	1.0	0.9	0.9	0.9	1.2	0.9	0.9	1.3
Virgin Islands	4.6	3.9	2.7	3.2	1.1	1.2	1.2	2.1	0.7	0.7	0.7
Washington	5.6	4.4	4.4	4.1	3.7	3.6	3.6	3.9	2.8	2.6	3.4
West Virginia	7.6	4.9	4.6	4.2	3.6	3.1	3.4	3.6	2.6	2.3	2.8
Wisconsin	4.7	3.4	3.5	3.0	2.7	2.2	2.5	3.3	2.0	1.8	2.3
Wyoming	4.4	2.3	2.4	3.9	3.2	2.3	2.9	2.7	1.6	1.0	1.4
United States	3.9	2.8	2.8	2.8	2.4	2.1	2.2	2.3	2.3	2.4	2.7

Prepared by DOL/ETA/UIS. Division of Actuarial Services.

TABLE 3.—SELECTED UNEMPLOYMENT RATES

[Monthly data seasonally adjusted]

Period	Unemployment rate (percent of civilian labor force in group)										
	Total (all civilian workers)	By sex and age			By race			By selected groups			
		Men 20 years and over	Women 20 years and over	Both sexes 16–19 years	White	Black	Black and other [1]	Experienced wage and salary workers	Married men, spouse present	Women who maintain families	Full-time workers	Part-time workers
1976	7.7	5.9	7.4	19.0	7.0	14.0	13.1	7.3	4.2	10.1	7.3	10.1
1977	7.1	5.2	7.0	17.8	6.2	14.0	13.1	6.6	3.6	9.4	6.6	9.9
1978	6.1	4.3	6.0	16.4	5.2	12.8	11.9	5.6	2.8	8.5	5.6	9.0
1979	5.8	4.2	5.7	16.1	5.1	12.3	11.3	5.5	2.8	8.3	5.3	8.8
1980	7.1	5.9	6.4	17.8	6.3	14.3	13.1	6.9	4.2	9.2	6.9	8.8
1981	7.6	6.3	6.8	19.6	6.7	15.6	14.2	7.3	4.3	10.4	7.3	9.4
1982	9.7	8.8	8.3	23.2	8.6	18.9	17.3	9.3	6.5	11.7	9.6	10.5
1983	9.6	8.9	8.1	22.4	8.4	19.5	17.8	9.2	6.5	12.2	9.5	10.4
1984	7.5	6.6	6.8	18.9	6.5	15.9	14.4	7.1	4.6	10.3	7.2	9.3
1985	7.2	6.2	6.6	18.6	6.2	15.1	13.7	6.8	4.3	10.4	6.8	9.3
1986	7.0	6.1	6.2	18.3	6.0	14.5	13.1	6.6	4.4	9.8	6.6	9.1
1987	6.2	5.4	5.4	16.9	5.3	13.0	11.6	5.8	3.9	9.2	5.8	8.4
1988	5.5	4.8	4.9	15.3	4.7	11.7	10.4	5.2	3.3	8.1	5.2	7.6
1989	5.3	4.5	4.7	15.0	4.5	11.4	10.0	5.0	3.0	8.1	5.1	6.2
1990	5.5	4.9	4.8	15.5	4.7	11.3	10.1	5.3	3.4	8.2	5.2	7.4

[1] Category includes: American Samoans, Native Americans, Asians, and Black Hispanics.

Source: Department of Labor, Bureau of Labor Statistics.

TABLE 4.—SELECTED MEASURES OF UNEMPLOYMENT

[Monthly data seasonally adjusted]

Period	Unemployment (thousands)	Percent distribution of unemployment by duration [1]				Percent distribution of unemployment by reason [1]			
		Less than 5 weeks	5–14 weeks	15–26 weeks	27 weeks and over	Job losers	Job leavers	Reentrants	New entrants
1977	6,991	41.8	30.5	13.1	14.7	45.3	13.0	28.1	13.6
1978	6,202	46.2	31.0	12.4	10.4	41.7	14.1	29.9	14.3
1979	6,137	48.1	31.7	11.5	8.7	42.9	14.3	29.4	13.3
1980	7,637	43.1	32.3	13.8	10.7	51.7	11.7	25.2	11.4
1981	8,273	41.7	30.7	13.6	14.0	51.6	11.2	25.4	11.9
1982	10,678	36.4	31.0	16.0	16.6	58.7	7.9	22.3	11.1
1983	10,717	33.3	27.4	15.4	23.9	58.4	7.7	22.5	11.3
1984	8,539	39.2	28.7	12.9	19.1	51.8	9.6	25.6	13.0
1985	8,312	42.1	30.2	12.3	15.4	49.8	10.6	27.1	12.5
1986	8,237	41.0	32.0	12.4	14.5	47.9	13.0	25.7	13.4
1987	7,425	43.7	29.6	12.7	14.0	48.0	13.0	26.6	12.4
1988	6,701	46.0	30.0	12.0	12.1	46.1	14.7	27.0	12.2
1989	6,528	48.6	30.3	11.2	9.9	45.7	15.7	28.2	10.4
1990	6,874	46.1	32.0	11.8	10.1	48.3	14.8	27.4	9.5

---

[1] Detail may not add to 100 percent because of rounding.

FAMILY INCOMES OF UNEMPLOYMENT INSURANCE (UI) RECIPIENTS [1]

INCOMES OF LONG-TERM UI RECIPIENTS

In the midst of long-term spells of UI receipt, the average unemployed worker's monthly family income was just under 80 percent of the level before the UI spell began (table 5). UI benefits, which replaced nearly one-half of the recipients' lost pretax earnings, were an important contribution, raising average incomes from less than 60 percent of their previous total. The earnings of other family members were even more important for many long-term UI recipients. Sixty percent of the long-term recipients were in families where at least one other person was working (usually the recipient's spouse); these earnings were often critical in maintaining family incomes.

TABLE 5.—EFFECTS OF UNEMPLOYMENT INSURANCE ON THE MONTHLY INCOMES OF LONG-TERM UI RECIPIENTS AND THEIR FAMILIES

	In base month [1]	In a month within a long-term spell of UI receipt		
		Total	Total excluding UI benefits [2]	Effect of UI benefits [2]
Average monthly income (dollars)	2,270	1,770	1,270	500
Average monthly income as a percentage of income in base month	100	78	56	22
Monthly poverty rate (percent)	[3] 9	[3] 19	[4] 46	−27

[1] The third month before the spell of UI began.

[2] Based on the assumption that the absence of UI benefits would not have affected other sources of income.

[3] The percentage of long-term recipients whose total monthly cash income was less than one-twelfth of the relevant annual poverty threshold.

[4] The percentage of long-term recipients who would have been poor if their UI benefits were not counted in total income and if the absence of UI benefits would not have affected their other sources of income.

Source: Congressional Budget Office calculations from the 1984 and 1985 panels of the Survey of Income and Program Participation, based on about 1,000 spells of Unemployment Insurance (UI) receipt that lasted for at least four consecutive months in 1984, 1985, and 1986.

Although UI is not a means-tested program, it apparently has prevented a significant fraction of long-term recipients from temporarily having their family income fall below their monthly poverty threshold (defined as one-twelfth of the relevant annual poverty threshold, or about $900 per month in 1985 for a family of four). Few long-term UI recipients had monthly family incomes below these thresholds before they became unemployed, and about 20 percent were poor in the midst of their spell of UI receipt. Yet, about 45 percent of them would have been poor in the absence of UI benefits—if other things, such as the earnings and receipt of welfare payments by the recipients and their families, remained the same. Thus, UI benefits may have prevented up to one-fourth of long-term recipients from having their monthly family incomes fall below the poverty line.

---

[1] This subsection is excerpted from a CBO study entitled "Family Incomes of Unemployment Insurance Recipients and the Implications for Extending Benefits," February 1990.

The likelihood of being poor while receiving UI was also closely related to the presence of other earners in the family. The monthly poverty rate was only 5 percent among long-term recipients in families where someone else was working. Among UI recipients who were the sole earners in their families, however, the poverty rate was over 40 percent. Without UI, these poverty rates would have been about 20 percent and 85 percent, respectively.

INCOMES AFTER UI BENEFITS ENDED

One-third of the long-term UI recipients whose experiences were examined in the CBO study were not working three months after their benefits ended (table 6). Their circumstances are particularly relevant to the debate over extending the duration of UI benefits because the bulk of any additional UI payments probably would have gone to them. Some of the other UI recipients who returned to work, however, would probably have continued to be unemployed had UI benefits been extended. They, too, would have received additional UI benefits. Two-thirds of long-term recipients were back at work, with average family incomes similar to their levels before UI began.

TABLE 6.—FAMILY INCOME 3 MONTHS AFTER A LONG-TERM SPELL OF UNEMPLOYMENT INSURANCE ENDED, AS A PERCENTAGE OF PREVIOUS FAMILY INCOME

	Percentage distribution of recipients	Average income, as a percentage of previous income [1]
All long-term UI recipients	100	88
Working [2]	67	98
Other earners [3]	40	102
No other earners	27	88
Not working [2]	33	67
Other earners [3]	21	78
No other earners	13	33

[1] Calculated by comparing the total cash income of a UI recipient's family three months after a long-term UI spell ended with that family's total cash income in the third month before the UI spell began.

[2] "Working" and "not working" refer to whether or not the long-term UI recipient had any earnings three months after the UI spell ended.

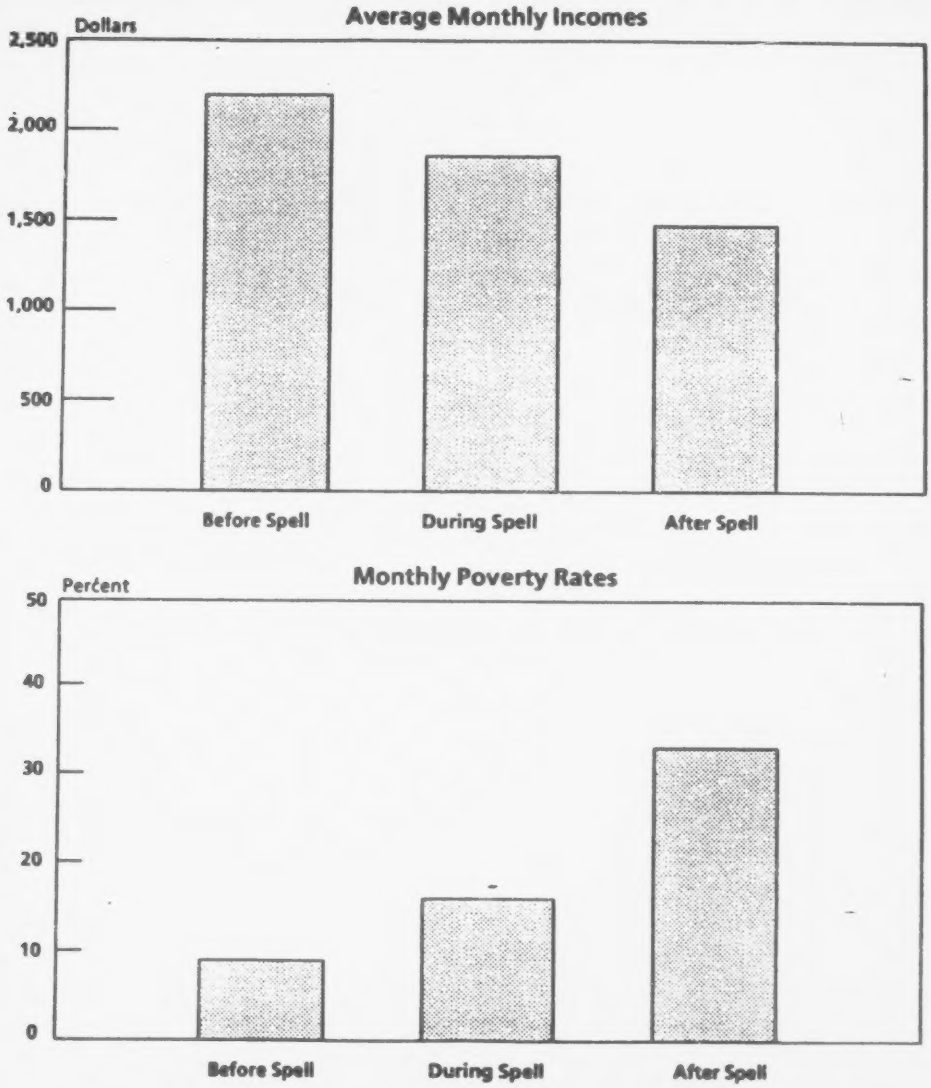
[3] "Other earners" were identified from the receipt of earnings by any other member in the UI recipient's family three months after the long-term UI spell ended.

Note: A long-term recipient had Unemployment Insurance (UI) benefits in four or more consecutive months during the 1984–1986 period. The period of receipt is termed a spell.

Source: Congressional Budget Office calculations from the 1984 and 1985 panels of the Survey of Income and Program Participation.

The majority of those not working incurred a substantial reduction in income. Their average family income was only about two-thirds of its level 3 months before their UI spell began (see chart 1). About one in three of those not working was poor on a monthly basis, whereas only one in six had been poor while receiving UI benefits. Married women and workers age 55 and older were disproportionately represented among those who had not returned to work, although this outcome might be different in a future recession.

CHART 1. FAMILY INCOMES AND POVERTY RATES OF LONG-TERM UNEMPLOYMENT INSURANCE RECIPIENTS NOT WORKING 3 MONTHS AFTER THEIR UI SPELLS ENDED



NOTE: The unemployment insurance (UI) recipients in this figure are those who had no earnings three months after the end of their long-term spells of UI (about one-third of the group depicted in table 5).

SOURCE: Congressional Budget Office calculations from the 1984 and 1985 panels of the Survey of Income and Program Participation. See CBO study for description of these data and their limitations.

The worst off among the UI recipients who had not returned to work were the approximately 40 percent who had no other earners in their families. Two of every three families were poor. Overall, this group had an average family income of about $500 per month—only about one-third of its previous level. Social Security benefits and pensions accounted for one-half of this group's average income.

The unemployed living in families with other earners—most often the spouse—fared better, but nonetheless were worse off than before their UI spells had begun. Their average monthly family income was nearly $2,100—about 80 percent of its earlier level—and about 10 percent of them were poor. Most of their incomes were the earnings of other family members.

TABLE 7.—AVERAGE UNEMPLOYMENT RATES BY STATES FOR CALENDAR YEARS 1982–90

[In percent]

State	1982	1983	1984	1985	1986	1987	1988	1989	1990
Alabama	14.4	13.7	11.1	8.9	9.8	7.8	7.2	7.0	6.8
Alaska	9.9	10.3	10.0	9.7	10.8	10.8	9.3	6.7	6.9
Arizona	9.9	9.1	5.0	6.5	6.9	6.2	6.3	5.2	5.3
Arkansas	9.8	10.1	8.9	8.7	8.7	8.1	7.7	7.2	6.9
California	9.9	9.7	7.8	7.2	6.7	5.8	5.3	5.1	5.6
Colorado	7.7	6.6	5.6	5.9	7.4	7.7	6.4	5.8	4.9
Connecticut	6.9	6.0	4.6	4.9	3.8	3.3	3.0	3.7	5.1
Delaware	8.5	8.1	6.2	5.3	4.3	3.2	3.2	3.5	5.1
District of Columbia	10.6	11.7	9.0	8.4	7.7	6.3	5.0	5.0	6.6
Florida	8.2	8.6	6.3	6.0	5.7	5.3	5.0	5.6	5.9
Georgia	7.8	7.5	6.0	6.5	5.9	5.5	5.8	5.5	5.4
Hawaii	6.7	6.5	5.6	5.6	4.8	3.8	3.2	2.6	2.8
Idaho	9.8	9.8	7.2	7.9	8.7	8.0	5.8	5.1	5.8
Illinois	11.3	11.4	9.1	9.0	8.1	7.4	6.8	6.0	6.2
Indiana	11.9	11.1	8.6	7.9	6.7	6.4	5.3	4.7	5.3
Iowa	8.5	8.1	7.0	8.0	7.0	5.5	4.5	4.3	4.2
Kansas	6.3	6.1	5.2	5.0	5.4	4.9	4.8	4.0	4.4
Kentucky	10.6	11.7	9.3	9.5	9.3	8.8	7.9	6.2	5.8
Louisiana	10.3	11.8	10.0	11.5	13.1	12.0	10.9	7.9	6.2
Maine	8.6	9.0	6.1	5.4	5.3	4.4	3.8	4.1	5.1
Maryland	8.4	6.9	5.4	4.6	4.5	4.2	4.5	3.7	4.6
Massachusetts	7.9	6.9	4.8	3.9	3.8	3.2	3.3	4.0	6.0
Michigan	15.5	14.2	11.2	9.9	8.8	8.2	7.6	7.1	7.5
Minnesota	7.8	8.2	6.3	6.0	5.3	5.4	4.0	4.3	4.8
Mississippi	11.0	12.6	10.8	10.3	11.7	10.2	8.4	7.8	7.5
Missouri	9.2	9.9	7.2	6.4	6.1	6.3	5.7	5.5	5.7
Montana	8.6	8.8	7.4	7.7	8.1	7.4	6.8	5.9	5.8
Nebraska	6.1	5.7	4.4	5.5	5.0	4.9	3.6	3.1	2.2
Nevada	10.1	9.8	7.8	8.0	6.0	6.3	5.2	5.0	4.9
New Hampshire	7.4	5.4	4.3	3.9	2.8	2.5	2.4	3.5	5.6

TABLE 7.—AVERAGE UNEMPLOYMENT RATES BY STATES FOR CALENDAR YEARS 1982–90—Continued

[In percent]

State	1982	1983	1984	1985	1986	1987	1988	1989	1990
New Jersey	9.0	7.8	6.2	5.7	5.0	4.0	3.8	4.1	5.0
New Mexico	9.2	10.1	7.5	8.8	9.2	8.9	7.8	6.7	6.3
New York	8.6	8.6	7.2	6.5	6.3	4.9	4.2	5.1	5.2
North Carolina	9.0	8.9	6.7	5.4	5.3	4.5	3.6	3.5	4.1
North Dakota	5.9	5.6	5.1	5.9	6.3	5.2	4.8	4.3	3.9
Ohio	12.5	12.2	9.4	8.9	8.1	7.0	6.0	5.5	5.7
Oklahoma	5.7	9.0	7.0	7.1	8.2	7.4	6.7	5.6	5.6
Oregon	11.5	10.8	9.4	8.8	8.5	6.2	5.8	5.7	5.5
Pennsylvania	10.9	11.8	9.1	8.0	6.8	5.7	5.1	4.5	5.4
Puerto Rico	22.8	23.4	20.7	21.8	18.9	16.8	15.0	14.6	14.2
Rhode Island	10.2	8.3	5.3	4.9	4.0	3.8	3.1	4.1	6.7
South Carolina	10.8	10.0	7.1	6.8	6.2	5.6	4.5	4.7	4.7
South Dakota	5.5	5.4	4.3	5.1	4.7	4.2	3.9	4.2	3.7
Tennessee	11.8	11.5	8.6	8.0	8.0	6.6	5.8	5.1	5.2
Texas	6.9	8.0	5.9	7.0	8.9	8.4	7.3	6.7	6.2
Utah	7.8	9.2	6.5	5.9	6.0	6.4	4.9	4.6	4.3
Vermont	6.9	6.9	5.2	4.8	4.7	3.6	2.8	3.7	5.0
Virginia	7.7	6.1	5.0	5.6	5.0	4.2	3.9	3.9	4.3
Washington	12.1	11.2	9.5	8.1	8.2	7.6	6.2	6.2	4.9
West Virginia	13.9	18.0	15.0	13.0	11.8	10.8	9.9	8.6	8.3
Wisconsin	10.7	10.4	7.3	7.2	7.0	6.1	4.3	4.4	4.4
Wyoming	5.8	8.4	6.3	7.1	9.0	8.6	6.3	6.3	5.4

Source: Unpublished tabulation, Bureau of Labor Statistics.

EMPLOYMENT AND LABOR FORCE PROJECTIONS

Labor force changes

The work force and nature of work in the 1990's will depend upon demographic, economic, social, and technical factors, among others. The discussion which follows is based upon Bureau of Labor Statistics projections prepared in 1989. Examined are changes in the population, labor force, industries, and occupations that are expected by 2000.

Population changes affect the increase/decrease in employment opportunities by industry. As the characteristics of the population change, so does the nature of goods and services demanded. Population changes also influence the rate of increase in the size of the labor force, which in turn affects the difficulty or ease with which one finds a job. Of particular interest are the growth rate of the population and changes in the age structure of the population.

The post-World War II "baby boom" has been followed into the labor force by the "baby bust." Consequently, we are experiencing a slower growing labor force and one in which the average age will creep upward. In 1979 the civilian labor force totaled about 105 million and the median age was 34.3 years. By 2000 the level is projected to be about 141 million and the median age, 39.3 years. Additions to the labor force will be lower over this decade because fewer teenagers are in the population and because a slowdown in the number of women seeking jobs is projected. Nevertheless, women could account for more than half of all new entrants to the labor force (see table 8).

The aging of the baby-boom will result in 72 percent of the labor force in 2000 being between the ages of 25 and 54 (prime-age workers). In 1988, 69 percent of the labor force was made up of this age group. In fact, the relative growth of the prime-age labor force is projected to be greater than that of the total labor force. In particular, prime-age women could account for the largest increase in the labor force and also could have the highest growth rate.

Although the labor force is projected to continue to be predominantly composed of white workers, minority group members are expected to make up an increasing proportion. Hispanic workers' representation in the labor force could rise from 7.4 percent in 1988 to 10.1 percent in 2000; black workers' representation, from 10.9 percent to 11.7 percent. This trend is related to higher birth rates among blacks and Hispancis, as well as to assumptions about immigration by Hispanics (see table 9).

With a slowly growing labor force (especially among young workers) and continuing robust demand for employees, labor shortages might develop. This situation could help some groups (e.g., minorities) that historically have had difficulties in the job market. However, prospective employees will need to possess the skills that employers want. Occupational employment growth is projected to be most rapid among occupations that require some postsecondary education. Differences between some job requirements and the educational abilities of labor force participants have led some individuals to conclude that the Nation faces a shortfall of well-educated workers. With a below average rate of high school completion and an underrepresentation in occupations that are projected to experience rapid growth, blacks and Hispanics as a group are not well-positioned to take advantage of labor shortages.

Employment changes

The Bureau of Labor Statistics predicts that nearly all of the jobs created between 1988 and 2000 will be in the service-producing sector (see table 10). This sector includes the following industry groups: transportation, communications, and public utilities; trade (wholesale and retail); finance, insurance, and real estate; services; and government. Retail trade as well as private health services and business services, including data processing, temporary help agencies, and building services, are expected to grow faster and add more new jobs than any other industries.

Employment in goods-producing industries (mining, construction, manufacturing, and agriculture) is projected to increase quite modestly over the upcoming decade (see table 10). Durable goods manufacturing (e.g., primary and fabricated metals), nondurable manufacturing (e.g., textiles and apparel), agriculture, and mining (e.g., coal, oil) are expected to lose jobs between 1988 and 2000. Employment in the construction industry is expected to grow modestly.

The Bureau of Labor Statistics suggests two ways of looking at occupational employment projections. One is by the actual number of jobs expected to be added and the other is by rate of growth. The distinction is important because occupations currently with large numbers of workers could add a significant number of jobs but show a relatively low growth rate. On the other hand, occupations with few workers could show high rates of growth but actually add few new jobs. Among occupations with the largest job growth, many require a low level of skills, e.g., cashiers, janitors and cleaners, truck drivers, waiters and waitresses, salesworkers, and food preparation workers. Alternatively, several of the fastest growing occupations require a higher level of skills. Nevertheless, these fast-growing jobs (e.g., computer systems analysts) account only for a small portion of all the jobs that are projected to be added by 2000.

Just as there are occupations expected to grow over the next decade, there are occupations projected to decline. These occupations, such as sewing machine operators, farmers, and farm workers, are concentrated in industries which have been contracting over the past several years including apparel, textiles, and agriculture. Other occupations are projected to decline because of changes in technology. These include industrial truck and tractor operators, welders, typists, and hand packers.

TABLE 8.—CIVILIAN LABOR FORCE, BY SEX, AGE, AND RACE, ACTUAL 1972–88, AND MIDDLE GROWTH PROJECTIONS TO 2000

Group	Actual			Projected	1988–2000	
	1972	1979	1988	2000	Entrants	Net change
			In thousands			
Total, 16 years and over	87,037	104,960	121,669	141,134	42,832	19,465
Men	53,556	60,727	66,297	74,324	20,735	7,397
16 to 24	11,243	13,645	11,753	11,352	NA	−401
25 to 54	33,133	37,926	46,382	53,155	NA	6,773
55 and over	9,180	9,156	8,791	9,817	NA	1,026
Women	33,481	44,233	54,742	66,810	22,097	12,068
16 to 24	8,943	11,760	10,782	11,104	NA	322
25 to 54	19,192	26,594	37,659	48,112	NA	10,453
55 and over	5,346	5,879	6,301	7,594	NA	1,293
White	77,275	91,922	104,756	118,981	[1] 28,597	14,225
Black	8,748	10,665	13,205	16,465	[1] 5,385	3,260
Asian and other		2,373	3,709	5,688	2,364	1,979
Hispanic		5,215	8,982	14,321	6,486	5,339
			In percent			
Total, 16 years and over	100.0	100.0	100.0	100.0	100.0	100.0
Men	61.5	57.9	54.5	52.7	48.4	38.0
16 to 24	12.9	13.0	9.7	8.0	NA	−2.1
25 to 54	38.1	36.1	38.1	37.7	NA	34.8
55 and over	10.5	8.7	7.2	7.0	NA	5.3
Women	38.5	42.1	45.0	47.3	51.6	62.0
16 to 24	10.3	11.2	8.9	7.9	NA	1.7
25 to 54	22.1	25.3	31.0	34.1	NA	53.7
55 and over	6.1	5.6	5.2	5.4	NA	6.6
White	88.8	87.6	86.1	84.3	[1] 66.8	73.0
Black	10.1	10.2	10.9	11.7	[1] 12.6	16.7
Asian and other		2.3	3.0	4.0	5.5	10.2
Hispanic		5.0	7.4	10.1	15.1	27.4

[1] Unlike the rest of the table, these numbers do not include Hispanics.

NA—Not available.

Note: The labor force expands and contracts as people move into it (entrants) and leave it (leavers). The net change in the size of the labor force is the difference between entrants and leavers. Hispanic may be of any race. It is an overlapping category in all but the next-to-last column of the table.

Source: Bureau of Labor Statistics.

TABLE 9.—PARTICIPATION RATES AND PERCENT DISTRIBUTION OF CIVILIAN LABOR FORCE BY SEX, AGE, AND RACE FOR 1972 and 1988, AND MIDDLE GROWTH PROJECTION FOR 2000

Group	Participation rate			Percent distribution		
	Actual		Projected	Actual		Projected
	1972	1988	2000	1972	1988	2000
Total, 16 years and over	60.4	65.9	69.0	100.0	100.0	100.0
Men	79.0	76.2	75.9	61.5	55.0	52.7
16 to 19	58.1	56.9	59.0	5.1	3.4	3.1
20 to 24	83.9	85.0	86.5	7.8	6.2	4.9
25 to 34	95.7	94.3	94.1	14.2	16.2	11.7
35 to 44	96.4	94.5	94.3	11.9	13.2	14.3
45 to 54	93.2	90.9	90.5	12.0	8.7	11.6
55 to 64	80.4	67.0	68.1	8.2	5.6	5.5
65 and over	24.3	16.5	14.7	2.3	1.6	1.4
Women	43.9	56.6	62.6	38.5	45.0	47.3
16 to 19	45.8	53.6	59.6	4.1	3.2	3.1
20 to 24	59.1	72.7	77.9	6.2	5.7	4.8
25 to 34	47.8	72.7	82.4	7.6	13.0	10.7
35 to 44	52.0	75.2	84.9	6.9	11.0	13.2
45 to 54	53.9	69.0	76.5	7.5	7.0	10.2
55 to 64	42.1	43.5	49.0	4.9	4.1	4.4
65 and over	9.3	7.9	7.6	1.3	1.1	1.0
White	60.4	66.2	69.5	88.8	86.1	84.3
Men	79.6	76.9	76.6	55.3	47.9	44.8
Women	43.2	56.4	62.9	33.5	38.2	39.5
Black	60.2	63.8	66.5	10.1	10.9	11.7
Men	73.9	71.0	71.4	5.6	5.4	5.7
Women	48.8	58.0	62.5	4.5	5.4	6.0
Asian and other		65.0	65.5		3.0	4.0
Men		74.4	74.6		1.7	2.1
Women		56.5	57.5		1.4	1.9
Hispanic		67.4	69.9		7.4	10.1
Men		81.9	80.3		4.4	5.9
Women		53.2	59.4		2.9	4.3

Source: Bureau of Labor Statistics.

TABLE 10.—EMPLOYMENT BY MAJOR SECTOR, 1972, 1979, 1988, AND 2000 (PROJECTED)

Economic sector	Employment (in thousands) [1]			
	Actual			Projected 2000 [2]
	1972	1979	1988	
Total	85,549	101,353	118,104	136,211
Nonfarm wage and salary	73,514	89,481	104,960	122,056
Goods-producing	23,668	26,463	25,252	25,680
Mining	628	958	721	705
Construction	3,889	4,463	5,125	5,885
Manufacturing	19,151	21,042	19,406	19,090
Durable	11,050	12,762	11,436	11,220
Nondurable	8,101	8,280	7,970	7,870
Service-producing	49,846	63,018	79,708	96,376
Transportation and public utilities	4,541	5,135	5,548	6,096
Wholesale trade	4,113	5,204	6,029	6,936
Retail trade	11,835	14,989	19,110	22,875
Finance, insurance, and real estate	3,907	4,975	6,677	7,762
Services	12,117	16,768	24,971	33,718
Government	13,333	15,947	17,373	18,989
Agriculture	3,523	3,401	3,259	3,125
Private households	1,693	1,326	1,163	1,103
Nonfarm self-employed and unpaid family workers	5,819	7,145	8,722	9,927
	Percent distribution of employment			
Total	100.0	100.0	100.0	100.0
Nonfarm wage and salary	86.9	88.3	88.8	89.6
Goods-producing	28.0	26.1	21.3	18.6
Mining	.7	.9	.6	.5
Construction	4.6	4.4	4.3	4.3
Manufacturing	22.7	20.8	16.4	14.0
Durable	13.1	12.6	9.6	8.2
Nondurable	9.6	8.2	6.8	5.8
Service-producing	59.0	62.2	67.5	70.8
Transportation and public utilities	5.4	5.1	4.7	4.5
Wholesale trade	4.9	5.1	5.1	5.1
Retail trade	14.0	14.8	16.2	16.8
Finance, insurance, and real estate	4.6	4.9	5.7	5.7
Services	14.3	16.5	21.1	24.8
Government	15.8	15.7	14.7	13.9
Agriculture	4.2	3.4	2.8	2.3
Private households	2.0	1.3	1.0	.8
Nonfarm self-employed and unpaid family workers	6.9	7.1	7.4	7.3

[1] Includes wage and salary jobs, the self-employed, and unpaid family workers.

[2] Under moderate scenario.

Source: Bureau of Labor Statistics.

Displaced Workers

Job losses—both temporary and permanent—are a common feature of a dynamic market economy, as firms react to changes in supply and demand conditions and to changes in the regulatory environment in which they operate. Labor-saving technological improvements, changes in consumers' tastes, and changes in government policy can all affect the number of workers a firm desires to employ.

Temporary versus permanent layoffs

Whether a layoff is temporary or permanent has important implications for the workers involved and for considering what, if any policies might assist them. The major problem facing workers who have been temporarily laid off—those expecting to be recalled to their jobs—is income maintenance. Workers who have been permanently laid off, however, are likely to confront additional problems, especially if they have been with their previous employer for a number of years. For long-tenured workers, finding new jobs at comparable wages may be difficult if their skills and training are specific to one employer or one line of work. Moreover, long-tenured workers typically enter the labor market with no recent experience in how to find a job. Policies to assist workers who are permanently laid off—often referred to as "displaced" workers—have been the subject of discussion for a number of years.

Trends in displacement, 1981–88

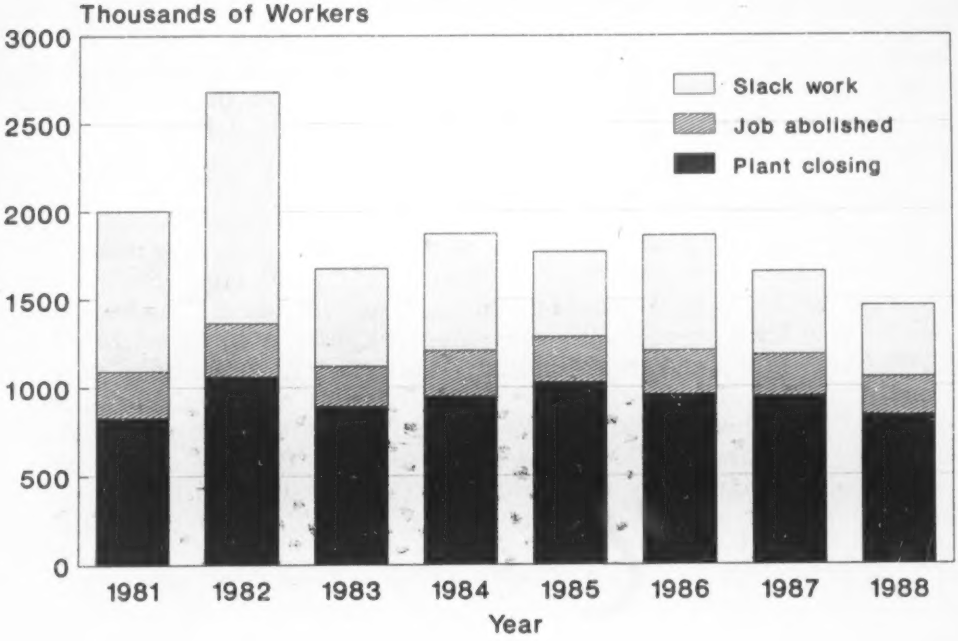
Data from supplements to the January 1984, 1986, 1988, and 1990 Current Population Surveys (CPS) indicate that 1.9 million adult workers (those 20 and older) lost full-time jobs, on average, each year between 1981 and 1988 because their employers closed or relocated, because their position or shift was eliminated, or because of slack work. Displacement was highly cyclical during this period, however, and job losses ranged from a high of 2.7 million workers in 1982, when the civilian unemployment rate reached a postwar high of 9.7 percent, to a low of 1.5 million workers in 1988, when the unemployment rate was 5.5 percent.[2]

Most of the cyclical variation in displacement during the 1980s is attributable to workers who reported being displaced because of slack work (see chart 2 and table 16). These workers accounted for 49 percent of all displaced workers in 1982, compared with 28 percent of those displaced in 1988.

---

[2] The use of the data from these supplements in this analysis differs in two important ways from the analyses reported by the Bureau of Labor Statistics (BLS) and many other analysts. First, all workers who reported losing jobs are included, not just those with 3 or more years of job tenure. Second, only those workers who were laid off in the second and third years preceding the survey are included. (For example, only data for workers who reported losing jobs in 1987 and 1988 were used from the January 1990 CPS.) This procedure is intended to reduce problems associated with response bias and to avoid including workers who were eventually recalled to their job.

CHART 2. WORKERS DISPLACED FROM FULL-TIME JOBS, 1981–88, BY REASON FOR JOB LOSS



NOTES: Displaced workers are those who were permanently laid off because their plant closed or relocated, because their job or shift was abolished, or because of slack work.

SOURCE: Congressional Budget Office tabulations of data from the January 1984, January 1986, January 1988, and January 1990 Current Population Surveys.

Characteristics of workers who lost jobs

Displacement is often characterized in popular discussion as a phenomenon affecting older, blue-collar men who have lost long-tenure jobs in goods-producing industries. This stereotype, although roughly accurate in terms of predicting the likelihood of being displaced, is less accurate as a description of the typical displaced worker.

Just over 25 percent of the 1.5 million workers who reported being displaced in 1988 were aged 45 and older and about 60 percent were men (see table 11). Although displaced workers as a group were almost equally divided between those who had been with their employers less than 3 years and those who had at least 3 years of job tenure, only about 25 percent of workers 45 and older had less than 3 years of job tenure.

Workers who lost jobs in goods-producing industries accounted for about 46 percent of all displacements. This share is almost double the share of goods-producing industries in total employment. Thus although the likelihood of displacement was much lower among services-producing industries, the sheer size of that sector made it an important contributor to the number of displaced workers.

Displacement was not limited to blue-collar workers with limited schooling. White-collar workers—including managers, professionals, and administrative support personnel—accounted for over 55 percent of all displaced workers. Over 80 percent of workers who were displaced in 1988 had at least 12 years of schooling, and 17 percent had at least a college-level education.

Outcomes following displacement

This section reports on the labor force status and earnings in January 1990 of workers who were displaced in 1988. At the time these workers were surveyed, from 13 to 25 months had passed since they lost their jobs.

Labor force status.—About 78 percent of the 1.5 million workers who reported being displaced in 1988 were employed in January 1990, although almost 60 percent of them had been jobless 5 or more weeks after being laid off (see table 12). Almost 10 percent of workers displaced in 1988 were unemployed in January 1990, and just over 12 percent were no longer in the labor force. Half of the workers who were not employed in January 1990 had worked since being laid off.

For workers displaced in 1988, the likelihood of being employed in January 1990 depended on a number of factors: how long they had been with their previous employers, the number of years of schooling they had completed, their age (in January 1990), their gender, and the 1988 unemployment rate in the State in which they lived.

Long-tenured workers were generally less likely to be reemployed: only 64 percent of workers who had 10 or more years of job tenure when they were displaced were employed in January 1990, compared with over 80 percent of workers with less job tenure. Their lower employment rate reflects both their greater likelihood of withdrawing from the labor force and a higher unemployment rate among those remaining in the labor force.

Workers who had not completed high school were much less likely to be employed in January 1990 than were other workers displaced in 1988. Only 66 percent were employed, compared with 79 percent of workers with 12–15 years of schooling and 88 percent of workers with 16 or more years of schooling. High school dropouts were also less likely to be employed even after taking into account the relatively greater number who were not in the labor force.

Older workers were generally much less likely to be employed, largely because of their greater rate of labor force withdrawal. Over 40 percent of workers aged 55 and older were not in the labor market in January 1990; the proportion rises to 57 percent of workers 65 and older. The effect of age on the likelihood of employment holds up even when other factors—such as job tenure—are held constant.

Men were more likely to be employed than women—both in total and when other factors are taken into account. This difference is primarily associated with the greater likelihood of a man remaining in the labor force: 91 percent of men displaced in 1988 were in the labor force in January 1990, compared with 82 percent of women.

Not surprisingly, workers who lived in States with higher unemployment rates were generally less likely to be employed than those who lived in States with lower unemployment rates. About 87 percent of workers who lived in States with unemployment rates below 4 percent were employed, compared with 78 percent of workers who lived in States with unemployment rates between 4 percent and 6 percent, and 74 percent of workers who lived in States with unemployment rates of 6 percent or more. Other things being equal, the employment rate dropped about 2 percentage points with each 1 percentage point increase in a State's unemployment rate.

The reason for displacement appears to have had little effect on the likelihood of finding work. The reemployment rate for workers who lost jobs because of a plant closing—an event viewed by many analysts as a possible criterion for identifying workers in need of assistance—was virtually identical to that for workers displaced because of slack work, and the fraction of the former group who were unemployed in January 1990 was only 1 percentage point higher than for the latter group.

Earnings on new jobs.—Many displaced workers experienced earnings losses in subsequent employment: almost 29 percent of the 1.1 million workers who were displaced in 1988 and who were employed in January 1990 had weekly earnings more than 20 percent below their previous earnings (see table 13).[3] At the same time, however, many workers experienced gains: 26 percent had weekly earnings at least 20 percent higher than their previous jobs.

Long-tenured workers were much less likely to find work at comparable wages. Among workers with from 1 to 4 years tenure on their old jobs, about 24 percent of those who were employed in January 1990 had weekly earnings more than 20 percent below their previous level. Almost 40 percent of workers with longer tenures experienced a comparable earnings loss. Other things equal, each year of additional job tenure was associated with a 1 percentage point reduction in the ratio of new to old weekly earnings.

Older workers, men, and whites were more likely to find jobs paying less than 80 percent of their previous earnings than were younger workers, women, and nonwhites. Much of this loss, however, is attributable to the effect of job tenure. The effect of gender and race on earnings reductions vanishes when job tenure is taken into account, and the effect of age is much less pronounced.

Overall, workers with less than 12 years of schooling were only slightly more likely to experience an earnings reduction of more than 20 percent. Taking other characteristics into account, however, each additional year of schooling is associated with a 1 percentage point gain in the ratio of new to old weekly earnings.

Somewhat surprisingly, workers who lived in States with relatively high unemployment rates incurred smaller earnings losses than those who lived in States with relatively low unemployment rates. This phenomenon may reflect the characteristics of the workers who were able to find new jobs, if better-qualified workers were among the first to be hired.

---

[3] Taking inflation into account would magnify these losses, although it is not certain that earnings on their old jobs would have kept up with inflation.

Unemployment insurance receipt and exhaustion

Unemployment insurance (UI) is the major program intended to provide temporary income maintenance to workers who lose jobs. Workers with sufficient earnings and employment during the base period would have been eligible for up to 26 weeks of UI benefits following displacement.

UI benefit recipiency.—About 54 percent of all workers displaced in 1988 reported receiving UI benefits after losing their jobs (see table 14). In general, the likelihood of receiving benefits was positively correlated with tenure on the previous job: only 39 percent of workers with job tenure less than 1 year received benefits, compared with 67 percent of workers with job tenure of 10 years or more.

Older workers were also more likely to receive UI benefits, reflecting in part their generally longer job tenures. Workers who lost jobs in goods-producing industries and those displaced by slack work were also more likely to receive UI benefits.

UI benefit exhaustion.—Displaced workers were much more likely than other job losers to exhaust their eligibility for UI benefits: about 44 percent of workers who lost jobs in 1988 and received UI benefits exhausted their eligibility. UI administrative records, in contrast, indicate that about 28 percent of all workers who began receiving UI benefits in 1988 exhausted their eligibility.

The workers most likely to exhaust their eligibility were those with very short tenures and those with very long tenures. The higher exhaustion rate among short-tenured workers probably reflects limited eligibility periods; workers with less than 1 year of job tenure may not have established eligibility for the maximum potential duration of 26 weeks. The higher exhaustion rate among long-tenured workers—who would have been more likely to be eligible for a full 26 weeks—reflects the fact that they took much longer to find new jobs.

Patterns in UI benefit exhaustion by gender, race, and years of schooling were much more visible than patterns in UI receipt. For example, the likelihood of receiving benefits was virtually identical for men and women, but men had an exhaustion rate almost 7 percentage points greater. Nonwhites and whites had roughly equal UI recipiency rates, but nonwhites had a much higher exhaustion rate. Finally, workers with less than 12 years of schooling were much more likely to exhaust their entitlement to UI benefits than those with more education.

UI recipiency and duration of joblessness.—Why did only half of the workers displaced in 1988 receive UI benefits? The CPS data do not permit eligibility of particular displaced workers to be established, but one important reason appears to be that many were jobless only a short time. Almost 60 percent of workers who did not receive UI benefits were jobless for less than 5 weeks (see table 15).

Many of the workers who were jobless only for 1 or 2 weeks may not have been eligible for benefits, and those jobless for slightly longer periods may not have bothered to apply. It is less clear why workers who were jobless more than 6 months did not receive UI benefits. Some may have exhausted their entitlement to benefits during temporary layoffs that preceded their permanent layoff.

Others may have withdrawn from the labor force following layoff and chosen not to apply for benefits.

TABLE 11.—CHARACTERISTICS OF WORKERS DISPLACED FROM FULL-TIME JOBS IN 1988, BY TENURE WITH PREVIOUS EMPLOYER

[In percent]

	All displaced	Tenure with previous employer	
		Less than 3 years	3 years or more
All (in thousands)	1,460	710	730
All (in percent)	100.0	100.0	100.0
Age:			
20–24	10.1	16.4	3.8
25–44	63.5	69.0	59.0
45–54	15.2	9.9	20.6
55+	11.1	4.7	16.7
Gender:			
Men	59.3	61.6	58.4
Women	40.7	38.4	41.6
Race:			
White	89.1	89.1	89.5
Nonwhite	10.9	10.9	10.5
Years of schooling:			
Less than 12 years	18.6	15.5	22.2
12–15 years	63.9	67.7	59.5
16 or more years	17.5	16.8	18.3
Industry of job lost:			
Goods-producing	46.0	43.0	49.1
Services-producing	49.4	52.5	46.5
Occupation of job lost:			
Blue collar	41.1	39.7	42.7
White collar	55.9	57.0	54.8
State unemployment rate:			
Less than 4 percent	14.1	12.9	15.6
4 to 5.9 percent	50.9	52.4	49.0
6 percent or more	35.0	34.7	35.4
Reason for job loss:			
Plant closing	57.5	52.5	61.9
Slack work	27.8	33.9	21.9
Job abolished	14.7	13.6	16.2

Notes: Components may not sum to totals because of rounding and because totals include persons with missing data. Industries included in goods-producing are agriculture, mining, construction, and manufacturing. All others are considered services-producing industries. Blue collar occupations are operatives, craft and repair, laborers, and farming. All other occupations are considered white collar.

Source: Congressional Budget Office tabulations of data from the January 1990 Current Population Survey.

TABLE 12.—JANUARY 1990 LABOR MARKET STATUS OF WORKERS DISPLACED FROM FULL-TIME JOBS IN 1988, BY SELECTED CHARACTERISTICS

Characteristic	Workers displaced (thousands)	Status in January 1990 (in percent)		
		Employed	Unemployed	Not in the labor force
All	1,460	77.9	9.6	12.5
Tenure with previous employer:				
Less than 1 year	200	73.7	15.1	11.2
1–2 years	510	83.0	8.1	8.9
3–4 years	220	84.0	7.3	8.7
5–9 years	250	80.9	7.1	11.9
10 or more years	260	63.6	13.0	23.4
Age:				
20–24	150	69.3	15.5	15.3
25–44	930	84.2	8.0	7.8
45–54	220	77.4	14.0	8.6
55+	160	50.3	7.2	42.5
Gender:				
Men	870	82.1	9.0	8.9
Women	590	71.8	10.4	17.8
Race:				
White	1,300	77.9	9.0	13.0
Nonwhite	160	77.8	7.8	4.4
Years of schooling:				
Less than 12 years	270	66.1	15.0	18.9
12–15 years	930	78.6	9.0	12.4
16 or more years	250	87.8	6.0	6.2
Industry of job lost:				
Goods-producing	670	76.3	11.6	12.2
Services-producing	720	80.7	8.1	11.1
Occupation of job lost:				
Blue collar	600	73.2	13.5	13.3
White collar	820	81.4	6.8	11.8
State unemployment rate:				
Less than 4 percent	210	87.3	6.4	6.3
4 to 5.9 percent	740	78.0	11.3	10.7
6 percent or more	510	73.9	8.3	17.8
Reason for job loss:				
Plant closing	840	77.6	10.4	12.0
Slack work	410	77.3	9.4	13.3
Job abolished	220	80.3	6.7	13.0

Notes: Components may not sum to totals because of rounding and because totals include persons with missing data. Industries included in goods-producing are agriculture, mining, construction, and manufacturing. All others are considered services-producing industries. Blue collar occupations are operatives, craft and repair, laborers, and farming. All other occupations are considered white collar.

Source: Congressional Budget Office tabulations of data from the January 1990 Current Population Survey. (Preliminary)

TABLE 13.—RATIO OF NEW TO OLD WEEKLY EARNINGS FOR WORKERS DISPLACED FROM FULL-TIME JOBS IN 1988 AND EMPLOYED IN JANUARY 1990, BY SELECTED CHARACTERISTICS

Characteristic	Number of workers displaced (thousands)	Ratio of new to old weekly earnings (percent)				
		Less than 80	80 to 94	95 to 104	105 to 119	120 or more
All	1,140	28.8	14.5	16.7	14.0	26.1
Tenure with previous employer:						
Less than 1 year	150	27.7	11.9	20.3	13.1	27.0
1–2 years	420	24.4	13.3	15.4	15.6	31.4
3–4 years	190	23.8	17.4	16.3	14.7	27.8
5–9 years	200	39.1	8.6	14.0	11.2	27.1
10 or more years	170	36.0	22.5	19.2	12.9	9.4
Age:						
20–24	100	23.8	14.5	9.3	19.2	33.2
25–44	780	28.0	14.3	15.7	14.1	27.9
45–54	170	33.6	15.0	26.9	10.9	13.7
55+	80	35.6	16.0	17.5	10.9	20.1
Gender:						
Men	710	26.8	13.4	17.7	14.7	27.3
Women	430	31.9	16.1	15.2	12.8	24.0
Race:						
White	1,010	29.6	13.2	16.3	14.5	26.4
Nonwhite	120	21.3	25.5	20.6	9.8	22.8
Years of schooling:						
Less than 12 years	180	25.7	19.9	11.0	16.0	27.4
12–15 years	730	29.5	13.8	16.3	14.7	25.8
16 or more years	220	28.8	12.2	23.3	9.7	26.0
Industry of job lost:						
Goods-producing	510	29.4	15.7	16.6	17.1	21.2
Services-producing	580	28.0	12.8	17.5	11.1	30.6
Occupation of job lost:						
Blue collar	440	26.4	16.5	14.5	15.0	27.6
White collar	660	29.6	13.0	18.7	13.6	25.1
State unemployment rate:						
Less than 4 percent	210	34.3	11.7	22.8	13.1	18.0
4 to 5.9 percent	740	30.7	11.0	13.6	17.0	27.7
6 percent or more	510	23.8	20.4	18.3	10.2	27.3
Reason for job loss:						
Plant closing	650	30.5	12.1	18.7	14.0	24.7
Slack work	310	23.0	18.6	12.5	16.0	29.9
Job abolished	170	33.6	15.7	17.1	9.9	23.8

Notes: Components may not sum to totals because of rounding and because totals include persons with missing data. Industries included in goods-producing are agriculture, mining, construction, and manufacturing. All others are considered services-producing industries. Blue collar occupations are operatives, craft and repair, laborers, and farming. All other occupations are considered white collar.

Source: Congressional Budget Office tabulations of data from the January 1990 Current Population Survey. (Preliminary)

TABLE 14.—RECIPIENCY AND EXHAUSTION OF UNEMPLOYMENT INSURANCE BENEFITS AMONG WORKERS DISPLACED FROM FULL-TIME JOBS IN 1988, BY SELECTED CHARACTERISTICS

Characteristic	Workers displaced (thousands)	Percent received benefits	Exhausted benefits as a percent of—	
			Recipients	Displaced
All	1,460	54.3	43.8	23.8
Tenure with previous employer:				
Less than 1 year	200	38.7	46.1	17.8
1–2 years	510	51.5	39.9	20.5
3–4 years	220	58.2	39.1	22.8
5–9 years	240	56.5	41.5	23.4
10 or more years	260	66.9	52.3	35.0
Age:				
20–24	150	48.6	30.7	14.9
25–44	930	51.4	40.1	20.6
45–54	220	62.8	38.7	24.3
55+	160	64.2	76.8	49.3
Gender:				
Men	860	54.8	46.5	25.5
Women	590	53.5	39.8	21.3
Race:				
White	1,300	54.4	42.5	23.1
Nonwhite	160	52.8	55.2	29.1
Years of schooling:				
Less than 12 years	270	51.9	61.3	31.8
12–15 years	930	56.0	41.0	23.0
16 or more years	250	50.3	35.9	18.0
Industry of job lost:				
Goods-producing	670	60.5	47.1	28.5
Services-producing	720	49.4	37.9	18.7
Occupation of job lost:				
Blue collar	600	56.4	45.4	25.6
White collar	810	52.5	41.8	21.9
State unemployment rate:				
Less than 4 percent	210	54.6	41.1	22.4
4 to 5.9 percent	740	53.4	41.2	22.0
6 percent or more	510	55.3	48.5	26.8
Reason for job loss:				
Plant closing	840	48.2	46.1	22.2
Slack work	410	64.4	43.7	28.1
Job abolished	210	58.6	36.6	21.5

Notes: Components may not sum to totals because of rounding and because totals include persons with missing data. Industries included in goods-producing are agriculture, mining, construction, and manufacturing. All others are considered services-producing industries. Blue collar occupations are operatives, craft and repair, laborers, and farming. All other occupations are considered white collar.

Source: Congressional Budget Office tabulations of data from the January 1990 Current Population Survey. (Preliminary).

TABLE 15.—RECEIPT OF UNEMPLOYMENT INSURANCE BENEFITS AMONG WORKERS DISPLACED FROM FULL-TIME JOBS IN 1988, BY TENURE WITH PREVIOUS EMPLOYER AND WEEKS OF JOBLESSNESS

Tenure with previous employer	Workers displaced (thousands)	Recipiency of unemployment insurance benefits (percent)	
		No	Yes
All	1,460	100.0	100.0
Weeks of joblessness:			
Less than 5 weeks	550	58.9	21.2
5 to 26 weeks	550	26.2	47.3
27 or more weeks	340	14.1	30.9
Less than 3 years tenure	710	100.0	100.0
Weeks of joblessness:			
Less than 5 weeks	310	57.4	27.6
5 to 26 weeks	270	26.0	49.8
27 or more weeks	130	15.9	21.7
3 or more years tenure	730	100.0	100.0
Weeks of joblessness:			
Less than 5 weeks	240	60.8	16.7
5 to 26 weeks	280	27.1	46.4
27 or more weeks	200	12.0	36.5

Notes: Components may not sum to totals because of rounding and because totals include persons with missing data. Weeks joblessness may include spells of unemployment as well as periods out of the labor force.

Source: Congressional Budget Office tabulations of data from the January 1990 Current Population Survey.

TABLE 16.—WORKERS DISPLACED FROM FULL-TIME JOBS, BY REASON FOR JOB LOSS, 1981–88

[In thousands, numbers to accompany chart 2]

Year	Total displaced	Reason displaced		
		Plant closing	Job abolished	Slack work
1981	2,000	830	260	910
1982	2,680	1,060	300	1,320
1983	1,680	890	220	560
1984	1,870	950	260	660
1985	1,770	1,030	260	480
1986	1,860	960	250	660
1987	1,650	950	230	470
1988	1,460	840	210	410

Notes: Displaced workers are those who were permanently laid off because their plant closed or relocated, because their job or shift was abolished, or because of slack work. Components may not sum to totals because of rounding.

Source: Congressional Budget Office tabulations of data from the January 1984, January 1986, January 1988, and January 1990 Current Population Surveys. (Preliminary)

TABLE 17.—EXHAUSTIONS—REGULAR STATE PROGRAMS

[In thousands]

	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
January	162	169	152	147	229	332	261	211	184	215	309	258	421	269	238	290	230	176	168	203
February	158	168	127	129	230	295	251	184	160	201	275	267	394	245	207	208	220	170	150	169
March	188	184	143	146	278	326	290	201	193	220	291	341	470	251	228	231	245	198	176	191
April	182	171	138	167	369	305	265	192	185	259	289	362	431	245	253	256	244	183	166	197
May	167	179	141	178	406	273	242	193	195	251	246	338	398	243	235	233	206	174	174	208
June	180	159	119	159	438	282	254	176	162	246	244	378	383	198	194	214	204	172	162	184
July	164	149	119	190	487	263	215	151	169	298	247	360	336	213	235	245	212	161	161	208
August	161	153	124	174	413	254	234	158	166	256	215	365	341	212	205	212	179	169	173	202
September	149	121	100	145	370	239	198	138	140	254	207	351	264	163	182	210	170	142	148	169
October	136	117	111	155	350	212	183	133	161	292	200	347	244	197	208	223	160	138	152	198
November	140	123	110	152	291	231	192	144	159	259	201	384	249	183	180	183	183	148	156	183
December	154	120	112	186	336	251	192	149	162	319	265	424	248	188	214	241	184	148	154	189
Total	1,942	1,811	1,495	1,926	4,195	3,262	2,776	2,030	2,037	3,072	2,989	4,175	4,180	2,607	2,579	2,746	2,408	1,979	1,940	2,301

NA.—Not available.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE 18.—STATE PROGRAM EXHAUSTIONS—EXTENDED BENEFITS

[In thousands]

	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
January	10	52	366	177	126	11	24	169	9	91	7	4	5	9	0	0
February	9	50	215	166	66	10	15	128	14	95	6	4	6	0	(1)	0
March	10	100	244	187	50	13	18	134	38	128	7	(1)	5	5	(1)	0
April	13	161	253	177	45	15	28	117	114	153	6	7	5	1	1	(1)
May	62	207	190	159	49	31	74	95	134	156	12	9	4	2	1	1
June	65	228	197	170	49	19	66	90	193	120	3	5	3	2	(1)	(1)
July	55	245	175	141	50	13	67	48	128	44	1	5	8	1	(1)	0
August	41	245	178	92	38	12	64	21	121	23	(1)	6	14	1	0	0
September	38	271	180	94	23	11	139	23	126	11	(1)	5	8	0	0	0
October	47	294	174	137	30	14	208	15	126	7	1	4	8	0	0	0
November	46	258	187	136	12	12	147	14	93	6	3	3	7	0	0	0
December	47	286	178	137	10	11	189	11	94	6	4	(1)	13	0	0	0
Year total	441	2,398	2,536	1,774	549	172	1,039	862	1,188	840	50	52	86	21	2	1

[1] Less than 500.

Note: 0 means 10 or less.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE 19.—BENEFIT EXHAUSTIONS UNDER FEDERAL SUPPLEMENTAL BENEFITS (1975–78) AND FEDERAL SUPPLEMENTAL COMPENSATION (1982–85)

[In thousands]

	Federal supplemental benefits				1979–81	Federal supplemental compensation				1986–90
	1975	1976	1977	1978		1982	1983	1984	1985	
January	....	169	91	49	....	....	226	225	98	....
February	7	164	80	6	....	....	419	168	80	....
March	33	181	96	1	....	....	315	145	89	....
April	33	169	97	....	....	....	68	113	83	....
May	73	136	112	....	....	....	113	115	75	....
June	105	129	63	....	....	....	730	95	33	....
July	185	108	49	....	....	....	352	96	....	....
August	150	103	58	....	....	....	291	94	....	....
September	149	74	51	....	....	....	300	79	....	....
October	157	81	119	....	....	18	215	90	....	....
November	145	92	48	....	....	350	130	81	....	....
December	174	93	35	....	....	314	424	81	....	....
Total	1,211	1,499	899	56	....	682	3,583	1,382	458	....

Note: (1) Data appearing in this table in previous editions were erroneous. (2) There was no program in 1979–81 and 1986–90. (3) Data for August and September 1975 were not available. The $299,000 difference between the total for the year and the sum of available monthly data was prorated between August and September. (4) FSC exhaustions are not additive because reachback provisions caused claimants to receive as many as 3 final payments.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE 20.—UNEMPLOYMENT COMPENSATION PAID BY PROGRAM IN FISCAL YEAR 1990

[In millions of dollars]

State	Programs		Total
	Regular	Extended	
Alabama	173	0	173
Alaska	86	5	91
Arizona	139	0	139
Arkansas	134	0	134
California	2,016	0	2,016
Colorado	142	0	142
Connecticut	397	0	397
Delaware	40	0	40
District of Columbia	80	0	80
Florida	415	0	415
Georgia	286	0	286
Hawaii	45	0	45
Idaho	56	0	56
Illinois	887	0	887

TABLE 20.—UNEMPLOYMENT COMPENSATION PAID BY PROGRAM IN FISCAL YEAR 1990—Continued

[In millions of dollars]

State	Programs		Total
	Regular	Extended	
Indiana	142	0	142
Iowa	137	0	137
Kansas	150	0	150
Kentucky	180	0	180
Louisiana	130	0	130
Maine	102	0	102
Maryland	236	0	236
Massachusetts	1,098	0	1,098
Michigan	1,122	0	1,122
Minnesota	351	0	351
Mississippi	100	0	100
Missouri	275	0	275
Montana	37	0	37
Nebraska	35	0	35
Nevada	81	0	81
New Hampshire	53	0	53
New Jersey	962	0	962
New Mexico	54	0	54
New York	1,811	0	1,811
North Carolina	276	0	276
North Dakota	23	0	23
Ohio	601	0	601
Oklahoma	101	0	101
Oregon	231	0	231
Pennsylvania	1,150	0	1,150
Puerto Rico	125	NA	NA
Rhode Island	156	4	160
South Carolina	125	0	125
South Dakota	9	0	9
Tennessee	235	0	235
Texas	770	0	770
Utah	57	0	57
Vermont	47	0	47
Virginia	163	0	163
Virgin Islands	2	0	2
Washington	394	0	394
West Virginia	94	0	94
Wisconsin	347	0	347
Wyoming	20	0	20

NA—Not available.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance, Division of Actuarial Services. Data include State programs and programs for Federal employees and ex-service members.

TABLE 21.—U.S. AVERAGE BENEFIT COST RATE: REGULAR STATE UI PLUS ONE-HALF OF EXTENDED BENEFIT AS PERCENT OF COVERED WAGES

Year	First quarter	Second quarter	Third quarter	Fourth quarter	Average
1971	NA	NA	NA	NA	1.28
1972	NA	NA	NA	NA	0.96
1973	NA	NA	NA	NA	0.75
1974	NA	NA	NA	NA	1.04
1975	2.45	2.38	1.90	1.56	2.06
1976	1.99	1.45	1.27	1.20	1.46
1977	1.76	1.19	0.98	0.95	1.20
1978	1.28	0.82	0.73	0.65	0.86
1979	1.08	0.78	0.74	0.76	0.84
1980	1.28	1.25	1.35	1.12	1.25
1981	1.39	1.03	0.93	1.02	1.09
1982	1.67	1.57	1.57	1.60	1.60
1983	1.96	1.45	1.01	0.84	1.30
1984	1.05	0.78	0.69	0.71	0.81
1985	1.04	0.81	0.75	0.74	0.83
1986	1.02	0.83	0.79	0.74	0.84
1987	0.95	0.72	0.63	0.54	0.70
1988	0.81	0.60	0.53	0.47	0.60
1989	0.76	0.59	0.56	0.55	0.61
1990	0.86	0.70	0.66	0.67	0.72

NA—Not available.

Source: DOL/ETA/UIS/DAS.

TABLE 22.—U.S. AVERAGE WAGE REPLACEMENT RATE: RATIO OF AVERAGE WEEKLY BENEFIT AMOUNT TO AVERAGE WEEKLY WAGE

Year	First quarter	Second quarter	Third quarter	Fourth quarter	Average
1971	0.347	0.346	0.344	0.356	0.348
1972	.356	.356	.355	.361	.357
1973	.354	.350	.343	.354	.350
1974	.349	.349	.358	.365	.355
1975	.352	.358	.366	.377	.363
1976	.363	.362	.356	.366	.362
1977	.358	.351	.347	.362	.354
1978	.360	.351	.345	.357	.353
1979	.350	.345	.345	.362	.351
1980	.350	.358	.359	.363	.357
1981	343	.346	.348	.363	.350
1982	.356	.362	.366	.377	.365
1983	.365	.364	.356	.357	.360
1984	.356	.355	.346	.357	.354

TABLE 22.—U.S. AVERAGE WAGE REPLACEMENT RATE: RATIO OF AVERAGE WEEKLY BENEFIT AMOUNT TO AVERAGE WEEKLY WAGE—Continued

Year	First quarter	Second quarter	Third quarter	Fourth quarter	Average
1985	.352	.350	.349	.359	.352
1986	.359	.361	.360	.363	.361
1987	.358	.358	.355	.357	.357
1988	.352	.348	.343	.347	.348
1989	.350	.352	.353	.363	.354
1990	.356	.362	.360	.364	.360

Prepared by DOL/ETA/UIS/DAS.

TABLE 23.—NUMBER UNEMPLOYED 27 WEEKS OR LONGER AS A PERCENT OF ALL UNEMPLOYED (UNADJUSTED)

Year	First quarter	Second quarter	Third quarter	Fourth quarter
1971	8.7	11.1	11.0	10.8
1972	12.1	13.5	10.8	9.8
1973	8.6	8.5	7.0	7.4
1974	6.8	8.3	7.5	7.1
1975	8.7	14.8	18.7	19.1
1976	19.7	20.1	16.7	16.3
1977	15.5	16.5	13.6	12.9
1978	11.1	11.8	10.1	8.7
1979	9.0	9.5	8.1	8.3
1980	8.3	9.9	11.1	13.5
1981	15.3	15.0	13.7	12.3
1982	13.0	16.7	17.1	19.4
1983	23.2	26.3	23.8	21.9
1984	21.0	21.0	17.7	16.5
1985	15.8	16.4	14.7	14.7
1986	13.8	15.0	14.6	14.2
1987	14.0	15.1	13.9	12.9
1988	12.3	12.9	11.7	11.1
1989	10.4	10.5	9.0	9.6
1990	9.5	10.2	10.4	10.2

Source: U.S. Department of Labor.

TABLE 24.—STATE TAXABLE WAGE BASES, END OF YEAR

State	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Alabama	$6,600	$6,600	$6,600	$6,600	$6,600	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000
Alaska	10,000	10,000	10,000	13,300	14,600	20,200	21,400	21,800	21,600	21,500	21,100	20,900	21,300
Arizona	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Arkansas	6,000	6,000	6,000	6,900	6,900	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,800
California	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Colorado	6,000	6,000	6,000	6,000	6,000	7,000	8,000	8,000	8,000	9,000	10,000	10,000	10,000
Connecticut	6,000	6,000	6,000	6,000	7,000	7,100	7,100	7,100	7,100	7,100	7,100	7,100	7,100
Delaware	6,000	6,000	6,000	6,000	6,600	7,200	8,000	8,000	8,250	8,500	8,500	8,500	8,500
District of Columbia	6,000	6,000	6,000	6,000	7,500	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000
Florida	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Georgia	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,500	7,500	7,500	7,500	8,500
Hawaii	9,800	10,400	11,200	12,200	13,100	13,800	14,600	15,100	15,600	16,500	8,700	18,600	19,900
Idaho	9,600	10,200	10,800	12,000	13,200	14,400	14,400	15,000	15,600	16,200	16,200	16,800	17,400
Illinois	6,000	6,000	6,500	6,500	7,000	8,000	8,000	8,500	8,500	8,500	9,000	9,000	9,000
Indiana	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Iowa	6,500	6,900	7,400	8,000	8,700	9,400	10,400	11,200	12,000	12,300	11,000	11,500	11,900
Kansas	6,000	6,000	6,000	6,000	6,000	7,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000
Kentucky	6,000	6,000	6,000	6,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000
Louisiana	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	8,500	8,500	8,500
Maine	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000

TABLE 24.—STATE TAXABLE WAGE BASES, END OF YEAR—Continued

State	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Maryland	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Massachusetts	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Michigan	6,000	6,000	6,000	6,000	6,000	8,000	8,500	9,000	8,500	9,500	9,500	9,500	9,500
Minnesota	7,500	8,000	8,000	8,000	8,300	9,000	9,800	10,300	10,700	11,200	11,700	12,200	12,900
Mississippi	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Missouri	6,000	6,000	6,000	6,000	6,600	7,000	7,000	8,000	8,000	7,500	7,000	7,000	7,500
Montana	6,000	7,400	7,600	7,800	8,000	8,200	8,400	8,600	12,200	12,400	12,600	12,800	13,200
Nebraska	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Nevada	6,900	7,400	7,900	8,400	9,300	10,200	10,700	11,100	11,400	11,700	12,100	12,600	13,300
New Hampshire	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
New Jersey	6,200	6,600	6,900	7,500	8,200	8,800	9,600	10,100	10,700	11,300	12,000	12,800	13,900
New Mexico	6,100	6,600	7,200	8,000	8,500	9,300	9,800	10,000	10,300	10,700	10,800	11,100	11,500
New York	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
North Carolina	6,000	6,000	6,000	6,000	6,000	7,000	8,200	8,700	9,200	9,600	10,100	10,700	11,100
North Dakota	6,000	7,000	7,600	8,400	9,240	10,150	10,400	10,700	10,800	10,800	11,000	11,200	11,500
Ohio	6,000	6,000	6,000	6,000	6,000	7,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000
Oklahoma	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	8,900	9,100	9,100	9,200	9,500
Oregon	8,000	9,000	10,000	10,000	11,000	12,000	13,000	13,000	14,000	14,000	14,000	15,000	16,000
Pennsylvania	6,000	6,000	6,000	6,300	6,600	7,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000
Puerto Rico	Total	Total	Total	Total	Total	Total	Total	7,000	7,000	7,000	7,000	7,000	7,000

Rhode Island	6,000	6,000	7,200	7,800	8,600	9,200	10,000	10,600	11,000	11,400	12,000	12,800	13,800
South Carolina	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
South Dakota	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Tennessee	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Texas	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	8,000	9,000	9,000
Utah	9,600	10,400	11,000	12,000	12,000	12,000	13,300	12,100	12,600	12,900	13,200	13,600	14,000
Vermont	6,000	6,000	6,000	6,000	6,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000
Virginia	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Virgin Islands	6,000	6,000	6,000	6,000	8,000	8,000	8,000	14,000	14,500	14,000	16,500	16,500	17,000
Washington	8,400	9,000	9,600	10,200	10,800	11,400	12,000	10,000	11,500	13,200	15,100	15,600	16,200
West Virginia	6,000	6,000	6,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000
Wisconsin	6,000	6,000	6,000	6,000	6,000	8,000	9,500	9,500	10,500	10,500	10,500	10,500	10,500
Wyoming	6,000	6,000	6,000	6,000	6,000	7,000	9,900	9,500	9,900	10,300	10,200	10,400	10,400
United States	6,000	6,000	6,000	6,000	6,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000

Note: Until 1985, Puerto Rico had no limit on the wage base and thus total wages were subjected to tax.

Sources: U.S. Congress, House of Representatives, Committee on Ways and Means. Federal-State Unemployment Compensation System. WMCP 100–39. Washington: U.S. Government Printing Office, September 8, 1988, 169. U.S. Deptartment of Labor, Employment and Training Administration, Unemployment Insurance Service. Comparison of State Unemployment Insurance Laws. September 1990.

TABLE 25.—UNEMPLOYMENT COMPENSATION RATIO OF TAXABLE TO TOTAL WAGES, BY STATE, FOR SELECTED YEARS 1947–86

[In percent]

State	1947	1960	1970	1975	1980	1982	1986
U.S. total	0.84	0.61	0.48	0.45	0.45	0.40	0.41
Alabama	.91	.67	.51	.50	.51	.46	.46
Alaska	.91	.87	.68	.61	.50	.47	.68
Arizona	.89	.62	.54	.47	.46	.41	.40
Arkansas	.92	.74	.58	.55	.52	.51	.48
California	.83	.65	.51	.42	.42	.36	.35
Colorado	.86	.62	.46	.45	.44	.38	.41
Connecticut	.85	.59	.45	.52	.40	.38	.32
Delaware	.80	.61	.47	.39	.38	.36	.40
District of Columbia	.82	.60	.43	.41	.39	.39	.35
Florida	.88	.67	.50	.50	.50	.44	.43
Georgia	.88	.69	.51	.49	.47	.41	.41
Hawaii	.89	.69	.68	.66	.68	.70	.69
Idaho	.90	.67	.57	.50	.67	.69	.69
Illinois	.81	.56	.41	.40	.41	.39	.38
Indiana	.86	.59	.44	.43	.41	.38	.37
Iowa	.88	.63	.46	.45	.50	.51	.58
Kansas	.88	.63	.48	.48	.45	.40	.48
Kentucky	.90	.65	.49	.47	.45	.49	.44
Louisiana	.87	.64	.48	.46	.45	.38	.40
Maine	.91	.70	.52	.54	.51	.46	.44
Maryland	.87	.63	.46	.44	.43	.37	.37
Massachusetts	.85	.62	.50	.44	.46	.42	.38
Michigan	.83	.54	.46	.38	.37	.33	.39
Minnesota	.85	.59	.59	.48	.51	.46	.47
Mississippi	.92	.74	.57	.56	.53	.46	.46
Missouri	.84	.60	.44	.44	.43	.40	.41
Montana	.90	.67	.52	.54	.63	.62	.71
Nebraska	.86	.65	.49	.46	.46	.42	.42
Nevada	.87	.71	.56	.59	.59	.57	.59
New Hampshire	.91	.70	.51	.52	.48	.42	.41
New Jersey	.84	.57	.48	.45	.45	.44	.46
New Mexico	.91	.65	.51	.52	.54	.54	.55
New York	.79	.57	.41	.40	.39	.34	.32
North Carolina	.91	.73	.54	.53	.50	.44	.52
North Dakota	.88	.68	.59	.46	.55	.56	.57

TABLE 25.—UNEMPLOYMENT COMPENSATION RATIO OF TAXABLE TO TOTAL WAGES, BY STATE, FOR SELECTED YEARS 1947–86—Continued

[In percent]

State	1947	1960	1970	1975	1980	1982	1986
Ohio	.84	.56	.42	.41	.40	.36	.39
Oklahoma	.86	.64	.49	.48	.43	.37	.46
Oregon	.87	.73	.53	.52	.61	.59	.63
Pennsylvania	.86	.60	.50	.43	.42	.40	.40
Puerto Rico	.00	.00	.68	1.00	1.00	1.00	.59
Rhode Island	.87	.74	.55	.53	.54	.55	.55
South Carolina	.92	.74	.54	.54	.50	.45	.44
South Dakota	.89	.67	.51	.53	.50	.45	.46
Tennessee	.89	.68	.54	.46	.48	.43	.41
Texas	.86	.63	.48	.47	.44	.38	.38
Utah	.88	.62	.60	.48	.65	.62	.58
Vermont	.91	.69	.55	.51	.50	.44	.47
Virginia	.89	.67	.51	.49	.48	.41	.39
Virgin Islands	NA	NA	NA	NA	.54	.34	.78
Washington	.87	.60	.44	.58	.56	.55	.53
West Virginia	.87	.60	.51	.43	.42	.47	.42
Wisconsin	.85	.58	.51	.43	.42	.34	.50
Wyoming	.89	.66	.58	.49	.44	.38	.51

Note.—NA denotes not applicable.

Source: U.S. Congress, House of Representatives, Committee on Ways and Means. Federal-State Unemployment Compensation System. WMCP 100–39. Washington: U.S. Government Printing Office, Sept. 8, 1988, 146.

TABLE 26.—1980 AND 1989 WEEKLY PRETAX UC REPLACEMENT RATIOS BY STATE FOR LOW-WAGE, AVERAGE-WAGE, AND HIGH-WAGE EARNERS AND AVERAGE RATIO OF THE INSURED UNEMPLOYMENT RATE TO TOTAL UNEMPLOYMENT RATE FOR 1980–89

State	Low-wage [1] earner		Average-wage [1] earner		High-wage [1] earner		1980–89 IUR/TUR (percent)	1990 percent of unemployed receiving benefits
	1980	1989	1980	1989	1980	1989		
Alabama	0.50	0.54	0.25	0.28	0.14	0.16	26	28
Alaska	.57	.55	.42	.37	.23	.20	53	68
Arizona	.52	.52	.25	.30	.14	.17	26	29
Arkansas	.50	.50	.35	.42	.19	.23	32	34
California	.47	.44	.34	.32	.19	.18	42	47
Colorado	.60	.59	.40	.44	.22	.24	28	27
Connecticut	.50	.50	.38	.46	.21	.25	38	50
District of Columbia	.50	.57	.42	.55	.23	.30	38	44
Delaware [2]	.57	.57	.51	.40	.28	.22	33	27
Florida	.50	.50	.27	.39	.15	.22	19	21
Georgia [3]	.53	.52	.25	.34	.14	.19	26	27
Hawaii	.52	.52	.40	.47	.22	.26	42	37
Idaho	.50	.50	.34	.39	.19	.22	41	41
Illinois	.50	.49	.37	.36	.21	.20	33	33
Indiana	.46	.41	.21	.19	.11	.10	25	23
Iowa	.57	.56	.37	.35	.20	.19	31	34
Kansas	.55	.55	.34	.42	.19	.23	39	34
Kentucky	.57	.61	.34	.36	.19	.20	28	30
Louisiana	.52	.45	.42	.35	.23	.19	29	25
Maine	.59	.59	.27	.35	.15	.19	42	53
Maryland	.54	.54	.30	.40	.16	.22	33	32
Massachusetts [4]	.50	.50	.37	.50	.20	.27	49	60
Michigan [5]	.60	.65	.27	.51	.15	.28	32	35
Minnesota	.50	.50	.42	.50	.23	.27	35	37
Mississippi	.50	.50	.25	.28	.14	.16	28	27
Missouri	.59	.59	.29	.29	.16	.16	34	35
Montana	.50	.49	.33	.37	.18	.20	34	35
Nebraska	.54	.53	.30	.26	.16	.14	32	41
Nevada	.52	.52	.32	.38	.18	.21	34	39
New Hampshire	.50	.52	.35	.32	.19	.17	27	31
New Jersey	.50	.60	.36	.50	.20	.28	45	52
New Mexico	.61	.50	.32	.32	.18	.18	26	25
New York	.50	.50	.37	.48	.20	.26	39	49
North Carolina	.67	.50	.34	.46	.19	.25	32	40
North Dakota	.50	.50	.30	.36	.16	.20	39	34

TABLE 26.—1980 AND 1989 WEEKLY PRETAX UC REPLACEMENT RATIOS BY STATE FOR LOW-WAGE, AVERAGE-WAGE, AND HIGH-WAGE EARNERS AND AVERAGE RATIO OF THE INSURED UNEMPLOYMENT RATE TO TOTAL UNEMPLOYMENT RATE FOR 1980–89—Continued

State	Low-wage [1] earner		Average-wage [1] earner		High-wage [1] earner		1980–89 IUR/TUR (percent)	1990 percent of unemployed receiving benefits
	1980	1989	1980	1989	1980	1989		
Ohio	.50	.50	.36	.33	.20	.18	31	33
Oklahoma	.52	.52	.37	.38	.20	.21	25	22
Oregon	.65	.65	.36	.46	.20	.26	40	47
Pennsylvania	.53	.53	.45	.52	.25	.29	44	48
Puerto Rico	.44	.47	.20	.21	.11	.12	NA	NA
Rhode Island	.55	.60	.34	.47	.19	.26	63	59
South Carolina	.50	.50	.31	.32	.17	.18	31	32
South Dakota	.59	.50	.31	.27	.17	.15	21	17
Tennessee	.50	.44	.28	.30	.15	.17	29	41
Texas	.52	.52	.29	.41	.16	.23	21	23
Utah	.50	.50	.38	.41	.21	.22	31	27
Vermont	.50	.58	.32	.35	.18	.19	44	53
Virgin Islands	.52	.56	.25	.34	.14	.19	NA	NA
Virginia	.50	.52	.34	.32	.19	.17	18	20
Washington	.52	.52	.38	.46	.21	.25	39	51
West Virginia	.52	.55	.46	.48	.26	.26	31	26
Wisconsin	.52	.50	.43	.39	.24	.22	41	44
Wyoming	.52	.52	.37	.39	.20	.22	33	25
Number of jurisdictions where:								
1989 exceeds 1980	12		38		37			
1989 equals 1980	26		2		3			
1989 is less than 1980	15		13		13			

---

[1] For 1980, low, average and high earnings levels are derived by deflating 1989 low, average, and high earnings levels by the CPI–U. For 1989, low wages of $12,091 is the 1988 poverty threshold for a family of four. For 1989, average wages of $26,671 is the 1988 weighted average earnings from the U.S. Department of Commerce, Bureau of the Census. "Money, Income and Poverty Status," table 14, P–60, No. 166. Washington, 1989 p. 52. The high-wage worker is defined as having earnings of $48,364 in 1989, four times the 1988 poverty threshold for a family of four.

Low-wage worker is defined as having annual earnings of $8,422 in 1980 and $12,091 in 1989; average-wage worker is defined as having annual earnings of $18,578 in 1980 and $26,671 in 1989; and high-wage worker is defined as having annual earnings of $33,689 in 1980 and $48,364 in 1989. Replacement ratios are calculated by dividing benefits by the pretax weekly earnings (annual earnings divided by 52). Dependents' allowances are disregarded. UC benefit levels are those available in January 1980 and September 1989.

[2] For 1989: When the trust fund balance is at least $90 million. Otherwise, a different weekly benefit calculation formula applies.

[3] For 1989: Maximum weekly benefit amount declines, as will the replacement ratio, when the trust fund balance falls below $175 million.

[4] For 1989: When average weekly wage is greater than $66.

[5] For 1989: Michigan calculates the weekly benefit amount as 70 percent of after-tax earnings. For purposes of calculating after-tax earnings, worker is assumed to be married, filing jointly, with no dependents. Low-wage worker claims the earned income tax credit.

Source: 1980 derived from U.S. Department of Labor. Employment and Training Administration. "Significant Provisions of State Unemployment Insurance Laws, January 6, 1980." Washington, 1980. p.5

1989 derived from U.S. Dept. of Labor. Employment and Training Administration. Table 304, "Weekly Benefits for Total Unemployment." Washington, 1989. 4 p. For both 1980 and 1989, telephone calls to several States were made when the formula for calculating the weekly benefit amount was unclear.

The percent of unemployed receiving benefits was calculated by the Center on Budget and Policy Priorities based on U.S. Department of Labor data.

TABLE 27.—RATIO OF INSURED UNEMPLOYMENT TO JOB LOSERS

[Backup data to chart 6 in section 6]

Years	Job losers	Insured unemployment		Ratio: Insured unemployment to job losers	
		All programs	Regular programs	All programs	Regular programs
1968	1,070	1,187	1,111	110.9	103.8
1969	1,017	1,177	1,101	115.7	108.3
1970	1,811	2,070	1,805	114.3	99.7
1971	2,323	2,608	2,150	112.3	92.6
1972	2,108	2,192	1,848	104.0	87.7
1973	1,694	1,793	1,632	105.8	96.3
1974	2,242	2,558	2,262	114.1	100.9
1975	4,386	4,937	3,986	112.6	90.9
1976	3,679	3,846	2,991	104.5	81.3
1977	3,166	3,308	2,655	104.5	83.9
1978	2,585	2,645	2,359	102.3	91.3
1979	2,635	2,592	2,434	98.4	92.4
1980	3,947	3,837	3,350	97.2	84.9
1981	4,267	3,410	3,047	79.9	71.4
1982	6,268	4,594	4,061	73.3	64.8
1983	6,258	3,775	3,396	60.3	54.3
1984	4,421	2,561	2,476	57.9	56.0
1985	4,139	2,693	2,611	65.1	63.1
1986	4,033	2,746	2,650	68.1	65.7
1987	3,566	2,401	2,332	67.3	65.4
1988	3,092	2,248	2,081	72.7	67.3
1989	2,983	2,324	2,158	77.9	72.3
1990 (preliminary)	3,322	2,715	2,514	81.7	75.7

Source: Based on data from the Economic Report of the President, 1991.

TABLE 28.—NET BALANCES IN STATE ACCOUNTS

[In billions of dollars]

End of calendar year—	Actual	1990 dollars [1]
1960	6.419	22.8
1961	5.568	19.6
1962	6.039	21.1
1963	6.421	22.2
1964	7.090	24.2
1965	8.172	27.6
1966	9.665	31.8
1967	10.702	34.4
1968	11.716	36.3
1969	12.636	37.5
1970	11.903	34.1
1971	9.725	27.0
1972	9.403	25.3
1973	10.882	27.7
1974	10.520	24.9
1975	3.070	6.7
1976	0.871	1.8
1977	0.950	1.9
1978	4.554	8.5
1979	8.583	14.7
1980	6.592	10.4
1981	5.745	8.3
1982	−2.645	−3.6
1983	−5.803	−7.5
1984	2.205	2.8
1985	10.069	12.2
1986	15.402	18.1
1987	23.175	26.4
1988	31.104	34.0
1989	36.871	38.5
1990 [2]	39.077	39.1

---

[1] Adjusted to 1990 dollars using the fixed-weight GNF deflator.

[2] End of fiscal year.

Source: CBO based on DOL, UI Financial Data, and unpublished data.

TABLE 29.—STATUS OF ADMINISTRATION ACCOUNT (ESAA), FISCAL YEAR 1992 BUDGET

[In billions of dollars]

Fiscal year	1990	1991	1992	1993	1994	1995	1996
FUTA income		4.39	4.84	5.05	5.22	5.40	4.54
Interest earnings		0.15	0.15	0.17	0.16	0.16	0.13
State administration (outlays)		3.02	3.28	3.14	3.09	3.05	3.03
UI		1.98	2.26	2.19	2.14	2.11	2.08
ES, BLS, VETS		1.04	1.02	0.94	0.94	0.94	0.94
Federal administration		0.15	0.16	0.16	0.16	0.16	0.16
Balance (end of year)	2.24	2.52	2.84	3.23	3.41	3.61	2.72
Ceiling [1]	1.16	1.25	1.32	1.29	1.27	1.25	1.25
Excess	1.08	1.27	1.52	1.94	2.14	2.36	1.47
State administration (budget authority)		3.07	3.25	3.17	3.12	3.08	3.06
State administration limitation		3.61	4.64	4.80	4.96	5.13	4.31

[1] Statutory ceiling is 40 percent of current year's appropriation.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, "UI Outlook: FY 1992 President's Budget," February 1991.

TABLE 30.—STATUS OF EXTENDED BENEFIT ACCOUNT (EUCA), FISCAL YEAR 1992 BUDGET

[In billions of dollars]

Fiscal year	1990	1991	1992	1993	1994	1995	1996
FUTA income		0.72	0.54	0.56	0.58	0.60	0.50
Interest earnings		.64	.63	.63	.64	.65	.67
EB outlays—Federal share		.14	.03	.01	([1])	([1])	....
EUCA balance (end of year)	7.24	8.42	8.69	9.00	9.62	10.29	10.87
Ceiling [2]		7.55	7.83	8.40	9.04	9.69	10.35
Excess		.87	.86	.60	.58	.60	.52

[1] Less than $5 million.

[2] Statutory ceiling is 0.375 percent of covered wages.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, "UI Outlook: FY 1992 President's Budget," February 1991.

TABLE 31.—STATUS OF LOAN ACCOUNT (FUA), FISCAL YEAR 1992 BUDGET

[In billions of dollars]

	Fiscal year						
	1990	1991	1992	1993	1994	1995	1996
Income:							
FUTA income		0.18					
State repayments		.19	0.28	0.48	0.51	0.46	0.83
State interest payments		.01	.11	.28	.44	.54	.61
Interest earnings		.30	.39	.44	.50	.62	.81
Overflow from ESAA/EUCA		1.12	2.14	2.38	2.54	2.72	2.96
Outgo:							
State loans		.66	1.71	2.95	2.30	1.93	1.79
FUA balance (end of year)	2.21	3.35	4.57	5.20	6.88	9.28	12.70
Ceiling [1]		12.58	13.05	14.01	15.07	16.15	17.25
Excess (short fall)		9.23	8.48	8.81	8.19	6.87	4.55

[1] Statutory ceiling is 0.625 percent of covered wages.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, "UI Outlook: FY 1992 President's Budget," February 1991.

TABLE 32.—STATUS OF STATE ACCOUNTS—FISCAL YEAR 1992 BUDGET

[In billions of dollars]

	Fiscal year						
	1990	1991	1992	1993	1994	1995	1996
Income		19.04	21.23	25.68	28.44	30.47	31.60
Collections		15.60	17.19	20.38	23.64	25.79	26.33
Interest earnings		2.78	2.33	2.15	2.21	2.40	2.84
Loans		0.66	1.71	2.95	2.30	1.93	1.79
Excess reduced credits							
Outgo		24.65	24.99	24.63	23.64	23.44	22.94
Benefits		24.46	24.71	24.36	23.41	23.33	22.75
Lump-sum repayments		0.19	0.28	0.27	0.23	0.11	0.19
Balance (end of year)	39.68	34.07	30.31	31.16	35.68	42.35	50.38
Outstanding loans	0.60	1.08	2.50	4.98	6.77	8.25	9.21
Net balance (excluding loans)	39.08	32.99	27.81	26.18	28.91	34.10	41.17

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, "UI Outlook: FY 1992 President's Budget," February 1991.

TABLE 33.—THE LABOR FORCE, 1960–90

[Thousands of persons, age 16 and over]

Year	Civilian labor force					Civilian labor force participation rate [1]	Civilian employment/population rate [2]
	Total	Employment			Unemployment		
		Total	Agricultural	Nonagricultural			
1960	69,628	65,778	5,458	60,318	3,852	59.4	56.1
1970	82,771	78,678	3,463	75,215	4,093	60.4	57.4
1971	84,382	79,367	3,394	75,972	5,016	60.2	56.6
1972 [3]	87,034	82,153	3,484	78,669	4,882	60.4	57.0
1973 [3]	89,439	85,064	3,470	81,594	4,365	60.8	57.8
1974	91,949	86,794	3,515	83,279	5,156	61.3	57.8
1975	93,775	85,846	3,408	82,438	7,929	61.2	56.1
1976	96,158	88,752	3,331	85,421	7,406	61.6	56.8
1977	99,009	92,017	3,283	88,734	6,991	62.3	57.9
1978 [3]	102,251	96,048	3,387	92,661	6,202	63.2	59.3
1979	104,962	98,824	3,347	95,477	6,137	63.7	59.9
1980	106,940	99,303	3,364	95,938	7,637	63.8	59.2
1981	108,670	100,397	3,368	97,030	8,273	63.9	59.0
1982	110,204	99,526	3,401	96,125	10,678	64.0	57.8
1983	111,550	100,834	3,383	97,450	10,717	64.0	57.9
1984	113,544	105,005	3,321	101,685	8,539	64.4	59.5
1985	115,461	107,150	3,179	103,971	8,312	64.8	60.1
1986 [3]	117,834	109,597	3,163	106,434	8,237	65.3	60.7
1987	119,865	112,440	3,208	109,232	7,425	65.6	61.5
1988	121,669	114,968	3,169	111,800	6,701	65.9	62.3
1989	123,869	117,342	3,199	114,142	6,528	66.5	63.0
1990	124,787	117,914	3,186	114,728	6,874	66.4	62.7
Percentage change:							
1960–70	18.9	19.6	−36.6	24.7	6.3	1.7	2.3
1970–80	29.2	26.2	−2.9	27.6	86.6	5.6	3.1
1980–90	16.7	18.7	−5.3	19.6	−10.0	4.1	5.9

[1] Civilian labor force as percent of civilian noninstitutional population.

[2] Civilian employment as percent of civilian noninstitutional population.

[3] Beginning 1972, introduction of 1970 census data added about 800,000 to civilian noninstitutional population and 333,000 to labor force and employment. A subsequent adjustment based on 1970 census in March 1973 added 60,000 to labor force and to employment. Beginning 1978, changes in sampling and estimation procedures introduced into the household survey added about 250,000, to labor force and to employment. Unemployment levels and rates were not significantly affected. Beginning 1986, the introduction of revised population controls added about 400,000 to the civilian population and labor force and 350,000 to civilian employment. Unemployment levels and rates were not significantly affected.

Note: Labor force data are based on household interviews and related to the calendar week including the 12th of the month.

Source: Department of Labor, Bureau of Labor Statistics.

MEASURES OF AVERAGE EARNINGS OR COMPENSATION

Table 34 illustrates various measures of average real earnings and compensation. Column one is the most comprehensive measure and illustrates average annual earnings including self-employment earnings as reported to the Social Security Administration. Using this measure the average worker's earnings increased in real terms about 2 percent per year during the 1960s; gained no ground in real terms during the decade of the 1970s and gained approximately 1 percent per year during the 1980s.

The next two columns are based on establishment survey data and measure earnings per payroll job for primarily blue-collar workers. These measures, described in greater detail below, show no growth during the 1970s and during the 1980s showed real decline of approximately one-half of 1 percent per year.

The next four columns are based on the Current Population Survey and illustrate median earnings per employed worker aged 16 or over differentiated by sex. Overall median wages for males declined slightly during the 1970s and increased slightly during the 1980s. The median of the earnings distribution for females showed real increases of approximately 2 percent for both the decades of the 1970s and 1980s.

The picture changes if one only examines only full-year full-time workers. Full-year is defined as working at least 50 weeks per year and full-time is defined as working at least 35 hours per week or more. For these full-time workers, both male and female, real earnings increased by approximately one-half of 1 percent per year during the 1970s. During the 1980s, median earnings of males working full time showed no growth and earnings for the fully employed female showed real gains of about 1 percent per year.

All of the previous measures examined cash wages only. The final two measures of compensation also include fringe benefits. Total compensation per hour increased by over 3 percent per year during the 1960s, 1½ percent during the 1970s, and showed growth of only three-tenths of 1 percent during the 1980s.

TABLE 34.—COMPARISON OF VARIOUS MEASURES OF REAL EARNINGS AND COMPENSATION

Year	Social Security average annual earnings	Average weekly earnings	Average hourly earnings	Male		Female		Compensation per hour	Employment cost index
				Median earnings	Full year full time	Median earnings	Full year full time		
				(In nominal dollars)					
1960	4,007	80.67	2.09	NA	NA	NA	NA	21.2	NA
1970	6,186	119.83	3.23	7,152	8,966	2,730	5,323	36.9	NA
1971	6,497	127.31	3.45	7,388	9,399	2,986	5,593	39.3	NA
1972	7,134	136.90	3.70	7,991	10,202	3,182	5,903	41.8	NA
1973	7,580	145.39	3.94	8,682	11,186	3,268	6,335	45.4	NA
1974	8,031	154.76	4.24	9,121	11,889	3,563	6,970	49.9	NA
1975	8,631	163.53	4.53	9,674	12,758	3,953	7,504	54.8	NA
1976	9,226	175.45	4.86	10,301	13,455	4,296	8,099	59.7	NA
1977	9,779	189.00	5.25	11,037	14,626	4,674	8,618	64.5	NA

TABLE 34.—COMPARISON OF VARIOUS MEASURES OF REAL EARNINGS AND COMPENSATION—Continued

Year	Social Security average annual earnings	Average weekly earnings	Average hourly earnings	Male		Female		Compensation per hour	Employment cost index
				Median earnings	Full year full time	Median earnings	Full year full time		
1978....	10,556	203.70	5.69	12,133	15,730	5,249	9,350	70.1	NA
1979....	11,479	219.91	6.16	12,948	17,014	5,977	10,151	77.0	59.1
1980....	12,513	235.10	6.66	14,011	18,612	6,624	11,197	85.1	64.8
1981....	13,773	255.20	7.25	15,061	20,260	7,222	12,001	93.0	71.2
1982....	14,531	267.26	7.68	15,373	21,077	7,686	13,014	100.0	75.8
1983....	15,239	280.70	8.02	16,062	21,854	8,213	13,902	103.8	80.1
1984....	16,135	292.86	8.32	17,026	23,218	8,675	14,780	108.0	84.0
1985....	16,823	299.09	8.57	17,779	24,195	9,328	15,624	112.8	87.3
1986....	17,322	304.85	8.76	18,782	25,256	10,016	16,232	118.7	90.1
1987....	18,427	312.50	8.98	19,818	25,946	10,620	16,911	123.1	93.1
1988....	19,334	322.02	9.28	20,612	26,656	11,096	17,606	128.6	97.6
1989....	20,100	334.24	9.66	NA	NA	NA	NA	132.9	102.3
1990....	21,179	346.04	10.03	NA	NA	NA	NA	137.7	107.0
				(In constant 1990 dollars)					
1960....	16,043	322.98	8.37	NA	NA	NA	NA	84.9	NA
1970....	19,292	373.71	10.07	22,305	27,962	8,514	16,601	115.1	NA
1971....	19,416	380.45	10.31	22,078	28,088	8,923	16,714	117.4	NA
1972....	20,695	397.13	10.73	23,181	29,595	9,231	17,124	121.3	NA
1973....	20,728	397.58	10.77	23,742	30,589	8,937	17,324	124.2	NA
1974....	19,930	384.07	10.52	22,636	29,505	8,842	17,297	123.8	NA
1975....	19,781	374.78	10.38	22,171	29,239	9,060	17,198	125.6	NA
1976....	20,005	380.44	10.54	22,336	29,175	9,315	17,561	129.5	NA
1977....	19,929	385.18	10.70	22,493	29,807	9,525	17,563	131.4	NA
1978....	20,142	388.69	10.86	23,152	30,015	10,016	17,841	133.8	NA
1979....	19,980	382.76	10.72	22,537	29,614	10,403	17,668	134.0	102.9
1980....	19,583	367.93	10.42	21,927	29,128	10,367	17,523	133.2	101.4
1981....	19,689	364.81	10.36	21,530	28,962	10,324	17,156	132.9	101.8
1982....	19,577	360.07	10.35	20,712	28,397	10,355	17,534	134.7	102.1
1983....	19,707	362.99	10.37	20,771	28,261	10,621	17,978	134.2	103.6
1984....	20,002	363.04	10.31	21,106	28,782	10,754	18,322	133.9	104.1
1985....	20,138	358.02	10.26	21,282	28,962	11,166	18,702	135.0	104.5
1986....	20,357	358.25	10.29	22,072	29,680	11,771	19,076	139.5	105.9
1987....	20,893	354.31	10.18	22,470	29,418	12,041	19,174	139.6	105.6
1988....	21,050	350.60	10.10	22,441	29,022	12,081	19,169	140.0	106.3
1989....	20,878	347.18	10.03	NA	NA	NA	NA	138.0	106.3

TABLE 34.—COMPARISON OF VARIOUS MEASURES OF REAL EARNINGS AND COMPENSATION—Continued

Year	Social Security average annual earnings	Average weekly earnings	Average hourly earnings	Male		Female		Compensation per hour	Employment cost index
				Median earnings	Full year full time	Median earnings	Full year full time		
1990....	21,179	346.04	10.03	NA	NA	NA	NA	137.7	107.0
				Average annual growth rate					
1960–70....	1.9	1.5	1.9	NA	NA	NA	NA	3.1	NA
1970–80....	0.1	−0.2	0.3	−0.2	0.4	2.0	0.5	1.5	NA
1980–90 [1]..	0.8	−0.6	−0.4	0.3	0.0	1.9	1.1	0.3	0.5

NA—Not available.

[1] For several of the measures, this is the annual growth rate between 1980 and 1988.

The earnings measures (the columns labeled average weekly earnings and average hourly earnings in table 34) are based on the establishment survey data. They measure earnings per payroll job for private sector production and nonsupervisory workers. There is no correction for changes in the occupational or industrial mix or for full-time versus part-time work. The survey results cover about 60 percent of the total jobs in the United States. They are not measures of the growth of: earnings per surveyed person (since a person may have more than one job), earnings per household (since there may be multiple workers or jobs/worker in a household, or jobs in a household that are not covered by the survey), earnings per hour of full-time workers (since part-time workers are included), or earnings per straight-time equivalent hour (since, for example, an increase in the share of premium pay hours will cause this measure to grow faster than earnings per straight-time hour are increasing). Nor can they be said to measure the growth of a typical individual worker's earnings (since they cover only about 60 percent of all jobs, and an individual worker will not suffer an earnings decline because the occupational or skill mix of the Nation's job pool is shifting toward lower-wage jobs. The typical worker will be promoted and his earnings will therefore grow faster than the earnings series.

The "Handbook of Labor Statistics" notes: "Earnings are measured as pay before deductions for Social Security, unemployment insurance, group insurance, withholding tax, salary reduction plans, bonds and union dues. Earnings includes pay for overtime, shift premiums, holidays, vacations, and sick leave, but it excludes extraordinary bonuses. Hours includes overtime and vacation hours. Overtime premium hours are not converted to straight-equivalent hours. Average hourly earnings do not represent total labor costs per hour for the employer, because they exclude retroactive payments and irregular bonuses, various fringe benefits, and the employer's share of payroll taxes."

The payroll survey data on average hourly/weekly earnings for private nonfarm establishments includes full-time and part-time workers holding production or nonsupervisory jobs. The rate of growth of the earnings series would be depressed by shifts toward lower-paying jobs (and the growth of the weekly earnings series would be depressed by a shift toward part-time employment). The growth of the series would also be depressed if irregular bonuses constitute a larger share of compensation in 1990 than in 1979 or if overtime constitutes a smaller share. Note that the series excludes managerial workers, the self-employed, and government and agricultural workers.

Average earnings by education group

The educational attainment of workers affected how they fared in terms of changes in real earnings during the 1970s and 1980s (see table 35).[4] For those with less than a high school degree, average real earnings dropped from $12,190 in 1973 to $10,039 in 1987. (Earnings are in 1987 dollars as adjusted by the personal consumption expenditures deflator.) By 1987, then, the earnings of workers who did not complete high school were 82 percent of the 1973 level. Similarly, for workers with high school degrees, average real earnings fell from $17,145 in 1973 to $16,191 in 1987, so that their 1987 earnings were 94 percent as much as their 1973 earnings. In contrast, after suffering a dip between 1973 and 1979, the average real earnings of workers with more education subsequently rose. By 1987, the average real earnings of workers who had some college education and of workers with at least a college degree were 3 to 4 percent greater than they had been in 1973.

Rewards to additional schooling increased over the years, as well. Put another way, the earnings gap widened between individuals with different levels of education. As shown by the data in the columns headed "Indexed values," average real earnings for those with at least a college degree rose from 2.3 times in 1973 to 2.9 times in 1987 the earnings of those who lacked a high school degree. In addition, the wage differential between less and more educated workers appears to have widened to a greater extent in service than in goods industries. Consequently, in 1987, workers in goods-producing industries with at least a college degree had real earnings that were 2.4 times higher than the earnings of individual who lacked a high school degree. In contrast, workers in service industries with at least a college degree had real earnings that were 3.5 times more than the earnings of individuals who lacked a high school degree.

---

[4] Burtless, Gary (ed.) *A Future of Lousy Jobs? The Changing Structure of U.S. Wages.* Washington, the Brookings Institution, 1990. p. 2-3.

TABLE 35.—MEAN REAL ANNUAL EARNINGS, BY EDUCATION AND INDUSTRY, 1963, 1973, 1979, 1987

Work force[1]	Earnings (dollars)[2]				Ratio, 1987/1973	Indexed values (less than high school degree = 1.000)			
	1963	1973	1979	1987		1963	1973	1979	1987
Total	13,554	17,007	16,794	18,063					
By industry:									
Goods producing	17,015	20,344	20,652	19,864					
Services	12,253	15,088	14,873	16,615					
By education group:									
Less than high school degree	10,675	12,190	11,081	10,039	0.824	1.000	1.000	1.000	1.000
High school degree	14,292	17,145	16,292	16,191	0.944	1.339	1.406	1.470	1.613
Some college	14,574	16,427	16,236	16,939	1.031	1.360	1.348	1.465	1.687
College degree or more	22,519	28,140	26,469	29,213	1.038	2.110	2.309	2.389	2.910
By education and industry:									
Goods producing:									
Less than high school degree	14,563	16,637	15,685	13,768	0.828	1.000	1.000	1.000	1.000
High school degree	17,621	20,527	20,366	19,087	0.930	1.210	1.234	1.298	1.386
Some college	19,567	20,779	21,592	20,718	0.997	1.344	1.249	1.377	1.505
College degree or more	30,791	36,075	34,652	33,367	0.925	2.114	2.168	2.209	2.424

TABLE 35.—MEAN REAL ANNUAL EARNINGS, BY EDUCATION AND INDUSTRY, 1963, 1973, 1979, 1987—Continued

Work force [1]	Earnings (dollars) [2]				Ratio, 1987/1973	Indexed values (less than high school degree = 1.000)			
	1963	1973	1979	1987		1963	1973	1979	1987
Services:									
Less than high school degree	9,163	9,470	8,417	7,798	0.823	1.000	1.000	1.000	1.000
High school degree	12,649	14,845	13,876	14,365	0.968	1.380	1.568	1.648	1.842
Some college	12,356	14,198	13,926	15,167	1.068	1.348	1.499	1.654	1.945
College degree or more	20,157	25,530	24,232	27,446	1.075	2.200	2.696	2.879	3.520

Note.—Calculations from the Annual Demographic Files, Current Population Surveys, March 1964-March 1988.

[1] Goods producing: mining, construction, durable manufacturing, and nondurable manufacturing. Services: transportation, communications, utilities, wholesale and retail trade, finance, insurance, and real estate, business and repair services, entertainment and recreation services, and professional services.

[2] All dollar values are in 1987 prices as adjusted by the personal consumption expenditures (PCE) deflator.

Source: Burtless, Gary (ed.) "A Future of Lousy Jobs? The Changing Structure of U.S. Wages," Washington, the Brookings Institution, 1990, p. 74.

Changes in the earnings distribution

The previous discussion has focused on what has happened to average or median earnings per worker over time. An equally interesting question is what has happened to the distribution of earnings. Table 26 answers that question and provides substantial evidence that the earnings distribution has become more unequal.

The top fifth of earners received a larger percentage of total earnings in 1988 than in 1978, while the bottom three-fifths of earners received a smaller percentage (see table 36). For example, men in the top fifth of their respective earnings distributions experienced increases in their shares of total earnings: from 37.4 percent to 40.2 percent for whites; from 34.0 percent to 39.3 percent for blacks; and from 35.5 percent to 40.9 percent for Hispanics. Conversely, men in the bottom three-fifths had decreases in their shares of total earnings: from 39.5 percent to 36.7 percent for whites; from 41.3 percent to 36.9 percent for blacks; and from 40.8 percent to 35.7 percent for Hispanics. The same pattern of gains for those in the top fifth and losses for those in the bottom three-fifths of the earnings distribution was evident among working women as well.

TABLE 36.—DISTRIBUTION OF EARNINGS OF ALL EARNERS AND FULL-TIME, YEAR-ROUND EARNERS, 1978 AND 1988

Group and year	Thousands of earners	Mean earnings	Mean earnings in constant 1988 dollars	Percent share of aggregate earnings				
				Top fifth	Second fifth	Third fifth	Fourth fifth	Bottom fifth
All earners:								
1978	111,301	$10,286	18,195	48.1	26.0	16.2	7.9	1.8
1988	131,125	19,419	19,419	48.6	25.2	15.8	8.3	2.1
Full time, year round:								
1978	61,951	14,961	26,464	38.9	23.4	17.5	12.8	7.4
1988	79,522	26,679	26,679	41.0	23.4	16.9	12.1	6.7
Men, full time, year round:								
1978	41,036	17,526	31,001	37.3	23.3	18.3	13.6	7.5
1988	48,285	31,093	31,093	40.4	23.2	17.4	12.4	6.6
Women, full time, year round:								
1978	20,914	9,929	17,563	33.4	23.5	18.9	14.9	9.4
1988	31,237	19,854	19,854	37.3	23.6	17.9	13.4	7.8
Race or Hispanic origin, sex, and year—full time, year round:								
White men:								
1978	37,210	$17,936	31,727	37.4	23.2	18.3	13.6	7.6
1988	42,716	31,804	31,804	40.2	23.2	17.5	12.5	6.7
White women:								
1978	17,967	9,982	17,657	33.3	23.5	18.9	14.9	9.4
1988	26,206	20,091	20,091	37.4	23.6	17.9	13.4	7.8

Black men:								
1978	3,098	12,893	22,806	34.0	24.7	19.3	13.8	8.2
1988	4,108	23,374	23,374	39.3	23.9	17.3	12.5	7.1
Black women:								
1978	2,497	9,377	16,587	33.1	23.7	18.8	14.8	9.5
1988	3,985	17,811	17,811	35.5	24.2	18.6	13.5	8.3
Hispanic men: [1]								
1978	1,878	12,981	22,962	35.5	23.7	18.2	13.8	8.8
1988	3,608	21,697	21,697	40.9	23.4	16.7	12.0	7.0
Hispanic women: [1]								
1978	859	8,634	15,273	32.9	23.7	18.8	14.9	9.7
1988	1,966	16,860	16,860	38.0	23.6	17.5	13.0	8.0

[1] May be of any race.

Note: Constant dollars were calculated using the CPI-X1 price index.

Source: Ryscavage, Paul and Peter Henle. Earnings Inequality Accelerates in the 1980s. Monthly Labor Review, December 1990, p. 4 and 6.

Low Wage Earnings [5]

The percentage of men (from 25 to 54 years of age) earning less than $12,000 a year, a sum approximately equal to the poverty line for a family of four, rose significantly for all male demographic groups but increased faster among blacks and Hispanics than among whites. Between 1973 and 1987, the percentage of men earning less than $12,000 a year grew from 8.4 to 13.2 percent for whites, from 24.9 to 33.0 percent for blacks, and from 19.6 to 33.9 percent for Hispanics (see table 38).

Almost three quarters of all employed white men had at least high school educations in 1973. This increased to 89 percent by 1987. The percentage of white men with a college degree or higher increased from 23 to 31.2 percent over this period. Hispanics continued to have the lowest levels of educational attainment; 42.8 percent had less than a high school education in 1987, although this represents more than a 10 percentage point decline from 1973. College completion increased by more than 5 percentage points (see table 37).

Over this period, high school graduates became inceasingly likely to be low earners. Among blacks and Hispanics, even the incidence of low earnings for college graduates increased. As table 38 indicates, 8.3 percent of employed black college graduates earned less than $12,000 in 1973; 15 years later, 16.7 percent were low earners. The situation was even worse for Hispanics. The percentage of low earners more than tripled from 4.8 to 16.7 percent.

The incidence of low earnings increased substantially for men in all three race groups with high school education or less. White high school graduates experienced a rise from 6.4 to 15 percent and blacks, from 15.8 to 36.5 percent. In fact, a black high school graduate in 1987 was as likely to be a low earner as was a black high school dropout in 1973. In 1987, 27 percent of Hispanic high school graduates were low earners, up from 13.1 percent in 1973. Because we are focusing on the earnings distribution, only men between the ages of 25 and 54 are included. Men who have zero sampling weights, are self-employed, work without pay, report zero weeks of work or no family income during the year, and those who report currently being in school or retired or who were in school or retired for at least 26 weeks in the previous calendar year are excluded from this analysis. The $12,000 cutoff for low earnings is adjusted using the CPI-X1 price index.

---

[5] This section borrows heavily from a paper by Sheldon Danziger and Gregory Acs entitled "Educational Attainment, Industrial Structure, and Male Earnings, 1973–1987", Institute for Research on Poverty, December 1990.

TABLE 37.—THE EDUCATIONAL ATTAINMENT OF PRIME-AGE (25–54) EMPLOYED MEN

	Percentage of men who had completed these years of schooling				16	17+
	0–8	9–11	12	13–15		
Whites:						
1973	10.1	13.1	38.4	15.5	12.5	10.5
1979	6.0	10.2	36.6	19.1	15.1	13.1
1987	2.9	7.9	38.4	19.6	17.4	13.8
Blacks:						
1973	24.4	24.4	33.4	10.8	4.4	2.6
1979	13.7	20.4	38.7	17.3	6.0	3.9
1987	5.6	15.8	44.9	20.0	8.3	5.4
Hispanics:						
1973	40.9	14.8	25.3	12.2	4.1	2.5
1979	32.6	15.8	26.7	14.3	6.2	4.4
1987	28.3	14.5	29.6	14.0	8.5	5.0

Source: Danziger, Sheldon and Gregory Acs, "Educational Attainment, Industrial Structure, and Male Earnings, 1973–1987", Institute for Research on Poverty, December 1990. Tabulations from the 1974, 1980, and 1988 Current Population Surveys.

TABLE 38.—THE PERCENTAGE OF PRIME-AGE (25–54) EMPLOYED MEN WITH LOW EARNINGS BY EDUCATION

	Years of schooling completed						
	0–8	9–11	12	13–15	16	17+	All
Whites:							
1973	19.3	10.2	6.4	7.8	6.1	6.5	8.4
1979	23.3	15.4	8.9	10.3	6.4	7.1	10.1
1987	34.7	25.9	15.0	11.4	7.4	6.3	13.2
Blacks:							
1973	41.9	28.4	15.8	17.9	8.3	8.4	24.9
1979	47.3	32.2	21.8	18.2	12.6	15.2	26.0
1987	55.3	44.2	36.5	22.3	16.7	13.1	33.0
Hispanics:							
1973	28.2	21.1	13.1	7.4	4.8	19.9	19.6
1979	37.2	24.4	16.8	12.7	10.3	8.8	23.3
1987	52.2	40.5	27.0	22.1	16.7	13.6	33.9

Sources: Danziger, Sheldon and Gregory Acs, "Educational Attainment, Industrial Structure, and Male Earnings, 1973–1987", Institute for Research on Poverty, December 1990.

Tabulations from the 1974, 1980, and 1988 Current Population Surveys. The figures reported are the percentage of employed men in each cell with earnings of less than $12,000/year in 1987 CPI–X1 constant dollars.

THE FEDERAL MINIMUM WAGE

In 1938, following decades of consideration both at the State and at the Federal level, the Congress adopted the Fair Labor Standards Act (P.L. 75–718) which established basic national standards for minimum wages, overtime pay, and the employment of child workers. Commencing with very limited coverage in 1938, the measure has been amended through the years both to increase the minimum rate and to expand coverage [6] (see table 39). The act (the FLSA) is the basic Federal statute in the wage/hour and child labor fields, covering workers both in the public and private sectors.[7]

For general coverage purposes, the minimum wage under the FLSA was increased to $3.80 per hour as of April 1, 1990. It will rise to $4.25 per hour on April 1, 1991, and remain at that level until the Congress takes action to change it.[8] Forty hours has become the general preovertime workweek under the act. Both with respect to wages and to hours, there are numerous exceptions from these standards written into the act.

Because nearly a decade passed between the effective date of the last step increase in the Federal minimum wage mandated under the 1977 FLSA amendments (to $3.35 on January 1, 1981) and the effective date of the first step increase under the 1989 amendments (to $3.80 on April 1, 1990), the actual value of the minimum wage, in comparison with increases in the cost-of-living, declined sharply (see table 27). Thus, Public Law 101-157, while increasing the hourly rate of the minimum wage, has not made up for the real loss in value of the wage floor.[9]

Since 1981, there has been a gradual decline in the number of hourly paid workers "employed at or below" the Federal minimum rate. By 1988, the number so employed (at or below) had dropped to about 3.927 million from 7.824 in 1981.[10] However, one must recall that, during the period, the purchasing power or value of the minimum wage had declined as well. As the value of the minimum wage erodes, logically the number of persons employed at or below the minimum wage can be expected to decline as well, through attrition, in the face of increases in the general market rate.[11]

In large measure, analyses of the minimum wage population seem to rest upon one's definition of "youth" and of "adult." If one thinks of a youth as a person between 16 and 19 years of age (as they are defined for general FLSA purposes), then youth workers in 1988 made up 36.1 percent of wage and salary workers employed at or below the Federal minimum wage. This leaves 63.9 percent of such workers who are adults. However, even if one defines a youth as one under 25 years of age (as has sometimes been proposed), then the percentages are 58.1 percent youth and 41.9 percent adult. Whether defined as youth or adults, the majority of persons employed at and below the minimum wage are female: below the Federal Minimum, 76.4 percent; at the Federal minimum, 59.1 percent; at and below the Federal minimum wage, taken together, 65.0 percent.[12] (For the number of such workers, see table 40.)

---

[6] General amendments to the act were adopted in 1949, 1955, 1961, 1966, 1974, 1977 and 1989. Narrowly focused legislation has addressed specific aspects of the act at various times through the era.

[7] Most States have minimum wage and overtime pay standards and/or child labor laws. These are most often different from the Federal standard under the FLSA and are frequently different from each other as well. When State and Federal standards overlap, the higher standard prevails.

[8] U.S. Library of Congress. Congressional Research Service. "The Federal Minimum Wage: Changes Made by the 101st Congress and Their Implications." Issue Brief No. IB90082, by William G. Whittaker, April 16, 1990 (continuously updated). Washington, 1990. 15 p.

[9] In assessing the minimum wage, one must take into account that it is a "cash wage" and does not include a fringe benefit component. It is generally assumed that persons employed at or below the Federal minimum wage have a smaller total fringe benefit package than do persons employed at higher cash wages, which may make "total compensation" for minimum wage workers comparatively lower.

[10] By 1989, the number of hourly paid workers employed at or below the Federal minimum wage had dropped further to 3.162 million, according to the Bureau of Labor Statistics, U.S. Department of Labor.

[11] In 1977, under Public Law 95-151, the Congress had increased the Federal minimum wage to $2.65 per hour (effective January 1, 1978), and had mandated step increases in the minimum rate to $3.35 per hour after January 1, 1981. But, thereafter, the minimum remained fixed for 9 years as the cost-of-living and the general wage structure increased.

As the Federal minimum wage has evolved, extensions of coverage have usually been accompanied by statutory exemptions from the full impact of the act, in part, for economic reasons and, in part, as a matter of legislative compromise. Thus, within the act there is a special subminimum wage standard for full-time students employed on a part-time basis in the service and retail industries or by the academic institution which the students attend. There is a special wage for handicapped persons, negotiated between the handicapped (or their agents) and the employer on an individual basis and intended to reflect the productivity of the worker. Where employed persons are "customarily and regularly" tipped, they are treated differently for minimum wage purposes under the act, their employer being allowed to utilize a "tip credit" toward his minimum wage obligation. Then, under the 1989 FLSA amendments, a "training wage" subminimum was created that is different from the student subminimum.

These various subminima may apply separately or in combination: for example, a subminimum wage, adjusted for a tip credit. In addition, most States have minimum wage standards. These vary from one State to another and frequently differ from the Federal standards set forth in the FLSA. Where State and local standards are higher, they will normally supersede Federal standards in respect to a particular aspect of wage/hour law. The result is a diverse range of minima, related, to specific individual circumstances (see table 41).

TABLE 39.—FEDERAL MINIMUM WAGE RATES, 1938–1991

	Effective date	Minimum wage	Value of minimum wage[1]
Public Law 75–718 enacted June 25, 1938	October 1938	$0.25	
	October 1939	.30	
	October 1945	.40	
Public Law 81–393 enacted October 26, 1949.	January 1950	.75	
Public Law 84–381 enacted August 12, 1955.	March 1956	1.00	
Public Law 87–30 enacted May 5, 1961	September 1961	1.15	
	September 1963	1.25	

---

[12] Percentages are based upon data provided by the Bureau of Labor Statistics, U.S. Department of Labor, for "wage and salary" workers, paid hourly, for 1988.

TABLE 39.—FEDERAL MINIMUM WAGE RATES, 1938–1991—Continued

	Effective date	Minimum wage	Value of minimum wage[1]
Public Law 89–601 enacted September 23, 1966.	February 1967	1.40	...
	February 1968	1.60	...
Public Law 93–259 enacted April 8, 1974	May 1974	2.00	...
	January 1975	2.10	...
	January 1976	2.30	...
Public Law 95–151, enacted November 1, 1977.	January 1978	2.65	2.65
	January 1979	2.90	2.88
	January 1980	3.10	3.26
	January 1981	3.35	3.66
Public Law 101–157 enacted November 17, 1989.	April 1990	3.80	5.45
	April 1991	4.25	5.69

[1] Statutory minimum wage adjusted for inflation (Consumer Price Index for All Urban Consumers) after 1978. The April 1991 figure is based upon a February 1990 Data Resources, Inc., March 1991 inflation rate forecast of 4.5 percent.

TABLE 40.—HOURLY PAID WORKERS EMPLOYED DURING 1988 AT AND BELOW THE FEDERAL MINIMUM WAGE ($3.35 PER HOUR), BY AGE AND SEX [1]

[In thousands]

	Below the minimum		At the minimum		At and below the minimum	
	Male	Female	Male	Female	Male	Female
16 and over	311	1,008	1,066	1,542	1,377	2,550
20 and over	196	741	565	1,007	761	1,748
16 to 19 years	115	267	501	534	616	801
20 to 24 years	72	215	258	319	330	534
25 to 29 years	40	142	79	148	119	290
30 to 34 years	22	97	53	121	75	218
35 to 39 years	20	75	36	88	56	163
40 to 44 years	7	51	18	77	25	128
45 to 49 years	5	37	16	69	21	106
50 to 54 years	8	36	17	48	25	84
55 to 59 years	11	35	23	54	34	89
60 to 64 years	5	28	21	39	26	67
65 and over	8	25	45	44	53	69

[1] Due to rounding and disparities in the primary data, calculations may not total 100 percent.

Source: Based upon data provided by the U.S. Department of Labor. Bureau of Labor Statistics. Unpublished tabulations from the Current Population Survey, 1988 Annual Averages.

TABLE 41.—MINIMUM WAGE REQUIREMENTS, 1990–1993

Date	General minimum wage [1]	Minimum tip credit adjusted [2]	Subminimum wage option [3]	Subminimum wage option tip credit adjusted	"Training wage" under P.L. 101–157 [4]	"Training wage" under P.L. 101–157 tip credit adjusted [5]	FLSA section 14 handicapped [6]	State standard [7]
January 1, 1990	$3.35	$2.01	$2.85	$1.71	...	...	Open	Varies
April 1, 1990	3.80	2.09	3.23	1.78	3.35	$1.84	Open	Varies
April 1, 1991	4.25	2.13	3.61	1.81	3.61	1.81	Open	Varies
April 1, 1993	4.25	2.13	3.61	1.81	([8])	([8])	Open	Varies

---

[1] The general minimum wage under the Fair Labor Standards Act (FLSA) does not apply to the entire work force. Aside from such categorical coverage criteria as the small business ("enterprise") test or the interstate commerce test, there are numerous specific exemptions under Section 13(a) of the Act.

[2] For a "tipped employee" (a person who "customarily and regularly receives more than $30 a month in tips"), an employer may reduce the wage paid to such an employee by crediting up to 45 percent of tips actually received (after April 1, 1990) and 50 percent of tips actually received (after April 1, 1991) against his employer's minimum wage obligation. This option is not available in States where a tip credit is contrary to State law.

[3] The sub-minimum wage option (85% of the otherwise applicable Federal minimum rate) was available to employers of certain persons employed in retail and service industries, by academic institutions attended by the workers in question, and in certain other situations limited by statute and regulated by the U.S. Department of Labor.

[4] The "training wage" is available to any employer except an agricultural employer. It may only be utilized through a 90-day period by any one employer for any individual worker. But governing operation, eligibility and employer responsibilities under the "training wage" differ from those applicable to the sub-minimum wage option. This option is not available in States where a sub-minimum "training wage" is contrary to State law.

[5] Wage rates are discounted by the allowable tip credit and by the "training wage" as well. The Department of Labor (Spring 1990) advises that the relationship of the tip to the "training wage" is under study. This relationship could, therefore, change at some point. The tip credit/"training wage" option may not be available to employers in States in which either or both elements (the tip credit and/or the "training wage') are contrary to State law.

[6] Under Section 14(c) of the FLSA, where State permits, a special sub-minimum wage option is available to employers of handicapped persons. The wage rate, below the otherwise applicable minimum, is subject to negotiation between the employer and the individual worker, subject to criteria set forth in the statute and to regulations established by the Department of Labor. There is no statutory minimum.

[7] Most States have established minimum wage standards. Where the State standard is higher than the Federal standard, the higher normally prevails. State minimum wage requirements vary from one State to another and are often different from and, sometimes, in conflict with Federal requirements under the FLSA.

[8] The "training wage" program is experimental and expires on April 1, 1993.

Section 7. Aid to Families With Dependent Children (Title IV-A)

BACKGROUND AND ELIGIBILITY

Aid to dependent children was established by the Social Security Act of 1935 as a cash grant program to enable States to aid needy children without fathers. Renamed Aid to Families with Dependent Children (AFDC), the program provides cash welfare payments for (1) needy children who have been deprived of parental support or care because their father or mother is absent from the home continuously, is incapacitated, is deceased or is unemployed, and (2) certain others in the household of such child. Currently all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands operate an AFDC program. Although 1988 legislation provided that American Samoa could participate in the AFDC program, as of February 1991 it had not chosen to do so.

States define "need," set their own benefit levels, establish (within Federal limitations) income and resource limits, and administer the program or supervise its administration. Federal funds pay from 50 to about 80 percent of the AFDC benefit costs in a State (54 percent on average) and 50 percent of administrative costs.

Regardless of the method used to express the need standard, the Social Security Act requires that the standard be uniformly applied within the State or locality to all families in similar circumstances. While participating States must comply with the terms of the Federal legislation, the AFDC program is voluntary, and States traditionally have been at liberty to pay as little or as much in benefits as they choose. In addition to State variations in AFDC eligibility and benefit levels, the benefit levels vary primarily by family size and sometimes by shelter costs.

While optional prior to October 1, 1990, States that operate AFDC programs are now required to offer AFDC to children in two-parent families who are needy because of the unemployment of one of their parents (AFDC-UP). Eligibility for AFDC-UP is limited to those families in which the principal wage earner is unemployed but has a history of work. States that did not have an unemployed parent program as of September 26, 1988 may limit benefits under the AFDC-UP program to as few as 6 months in any 13-month period.

The Family Support Act of 1988 (Public Law 100-485) substantially revised the education and training requirements of the AFDC program. As of October 1, 1990, States are required to have a job opportunities and basic skills (JOBS) program. The new program is designed to help needy families with children avoid long-term welfare receipt. The JOBS program replaces the work incentive (WIN) and WIN demonstration programs, and incorporates other work requirements of previous law. In addition, the JOBS program must include an educational component. States are required to enroll virtually all able-bodied persons whose youngest child is at least age 3, provided State resources are available.

Families receiving AFDC are automatically eligible for Medicaid. The Family Support Act also requires that States provide transitional Medicaid benefits for those who lose AFDC eligibility as a result of increased hours of, or increased income from, employment or as a result of the loss of earnings disregards.

The Family Support Act requires that States guarantee child care if it is decided that child care is necessary for an individual's employment or participation in education or training activities, and requires that transitional child care be provided for families who lose AFDC eligibility as a result of increased hours of, or increased income from, employment or as a result of the loss of earnings disregards.

The AFDC statute also includes entitlement funds to the States to provide child care to families who are not receiving AFDC who need such care in order to work and would otherwise be at risk of becoming eligible for AFDC.

Finally, Federal law requires AFDC mothers to assign their child support rights to the State and to cooperate with welfare officials in establishing the paternity of a child and in obtaining support payments from the father.

TREATMENT OF INCOME AND RESOURCES

Federal AFDC law requires that all income received by an AFDC recipient or applicant be counted against the AFDC grant except that income explicitly excluded by definition or deduction. Moreover, AFDC law requires that certain persons be considered part of the AFDC assistance unit and that part of the income of certain other persons be counted in determining the AFDC eligibility status and benefit amount. In 1981, Congress required that a portion of the income of a stepparent be counted in determining AFDC eligibility and benefit amounts. In 1984, a standard definition of the AFDC assistance unit was established for the first time. Under this requirement, the parent(s) of a dependent child and any dependent brothers or sisters who are in the home are to be included in the AFDC unit, with eligibility and benefits based on the income and circumstances of this family unit. SSI recipients and children receiving foster care maintenance payments or adoption assistance are excluded from this requirement. In addition, if a minor who is living in the same home as her parents or legal guardians applies for aid as the parent of a needy child, a portion of the income of the minor's parents (or legal guardians) is to be counted as available to the filing unit.

Unearned income

States are required by Federal law and/or regulations to disregard certain income in determining the eligibility and benefits of families applying for or receiving AFDC. Unearned income not counted by the AFDC program includes the following: the first $50 of current monthly child support payments received by the family, certain Department of Education grants and loans to undergraduate students for educational purposes, the value of Department of Agriculture donated foods, benefits received from Child Nutrition programs, payments to VISTA workers, some payments to certain Indian tribes, and Agent Orange settlement payments.

Earned income

States are required by Federal law to disregard certain earned income when determining the amount of benefits to which a recipient family is entitled. Before OBRA of 1981, in order to provide a financial incentive for recipients to seek and maintain employment, Federal law required the deduction of an initial $30 in monthly earnings plus one-third of remaining earnings, plus work expenses (any expenses, including child care costs, reasonably attributable to the earning of income). When making an initial determination of eligibility, however, only work expenses were disregarded.

Amendments in OBRA of 1981 changed the order in which the disregards were applied, limited the disregard for work expenses to $75 per month, capped the child care disregard at $160 per month per child, and specified that the HHS Secretary could lower these sums for part-time work. The $30 plus one-third disregard was limited to a period of 4 consecutive months; recipients who left AFDC and then returned could not again qualify for this disregard for 12 months. States were prohibited from paying AFDC to any family with a *gross* income above 150 percent of the State's standard of need and were required to assume that working AFDC recipients received a monthly earned income tax credit (EITC), if they appeared eligible for it and regardless of when or if the credit was actually available. Under prior law, the EITC was counted only when received; most AFDC recipients did not receive the EITC on a monthly basis. These changes substantially reduced the amount of earnings a recipient could have and remain eligible for an AFDC payment.

In 1984, Congress further revised these disregards. The gross income limit was increased to 185 percent of the State standard of need, the work expense disregard of $75 per month was applied to both full- and part-time workers, and the $30 disregard—originally a part of $30 and one-third—was extended for an additional 8 months beyond the 4-month limit on the one-third deduction. The 1984 legislation also returned to prior law policy with respect to the earned income tax credit: it was to be counted only when actually received.

The Family Support Act of 1988 revised the treatment of earned income effective October 1, 1989. The earned income disregard is $90 per month, the maximum child care expense allowance is $175 per month per child ($200 for children under age 2), and the child care disregard is now calculated after other disregard provisions have been applied. Furthermore, States are now required to disregard the earned income tax credit in determining eligibility for and benefits under the AFDC program.

TABLE 1.—CALCULATION OF BENEFITS FOR A WORKER WITH LOW EARNINGS UNDER PRE-OBRA, OBRA, AND CURRENT LAW

	Pre-OBRA	OBRA		DEFRA			Current law (FSA)		
		First 4 months	After 4 months	First 4 months	After 4 months	After 12 months	First 4 months	After 4 months	After 12 months
Income:									
Gross earnings	581	581	581	581	581	581	581	581	581
EITC		+32	+32						
Gross income	581	613	613	581	581	581	581	581	581
Disregards:									
Initial disregards [1]	−30	−105	−75	−105	−105	−75	−120	−120	−90
One-third of rest	−194	(2)	(2)	(2)	(2)	(2)	−154	(2)	(2)
Child care	−100	−100	−100	−100	−100	−100	−100	−100	−100
One-third of rest	(2)	−136	0	−125	0	0	(2)	(2)	(2)
Other expenses	[3] −70	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Total disregards	394	341	175	330	205	175	374	220	190
Net countable income	187	272	438	251	376	406	207	361	391
AFDC benefits:									
$420 payment standard	233	148	0	169	44	14	213	59	29
$367 payment standard	180	95	0	116	0	0	160	[4] 6	0

---

[1] Pre-OBRA: $30 disregard. OBRA: Standard work expense deduction of $75 plus $30 in first 4 months. DEFRA: Standard work expense deduction of $75 plus $30 disregard in first 12 months; FSA: Standard work expense deduction of $90 plus $30 disregard in first 12 months.

[2] Not applicable.

[3] Itemized work expenses including payroll deductions and transportation.

[4] To receive an AFDC check, the benefit amount must equal at least $10.

Table 1 illustrates the impact of the 1981, 1984 and 1988 changes on a mother with two children working full-time at a low wage. The need and payment standard are assumed to be $420 per month, roughly equivalent to the payment level in a high benefit State, or $367 per month, the maximum payment level in the median State for a family of three in January 1991.

Resources

Allowable resources are limited, by Public Law 97-35, to $1,000 (equity value—i.e., market value minus any encumbrances) per family, excluding the home and one automobile if the family member's ownership interest does not exceed a limit chosen by the Secretary of Health and Human Services. In addition, States must disregard from countable resources burial plots and funeral agreements for members of the assistance unit. Also, for a limited time, States must exclude real property the family is making a "good faith" effort to sell, but only if the family agrees to repay benefits. HHS regulations set $1,500 as the equity value limit for the automobile and permit States to exclude from countable resources "basic items essential to day to day living," such as clothing and furniture. Previous regulations permitted States to adopt a counted resource limit as high as $2,000 per family member, but allowed States to consider the home and auto as counted resources.

MONTHLY REPORTING AND RETROSPECTIVE BUDGETING

AFDC eligibility and benefits are determined monthly. Public Law 97-35 required States to determine eligibility on the basis of the family's circumstances in the current month. Payment amounts were to be determined "retrospectively"—on the basis of the family's countable income and resources in the preceding month (or, at the discretion of the Secretary of Health and Human Services, the second preceding month). In addition, States were to require recipients to provide monthly reports on income, family composition, and resources. However, the Secretary could waive this requirement if the State demonstrated that it would be cost-beneficial to do so. The only categories of recipients that could not be exempted were those with earned income or a recent work history.

In 1984, Public Law 98-369 revised these monthly reporting and retrospective budgeting requirements. Retrospective budgeting was mandatory only for cases which file a monthly report. Monthly reporting was required for cases with earned income or a recent work history and whenever cost effective.

The Omnibus Budget Reconciliation Act of 1990 gave States the option of specifying which categories of AFDC families, if any, have to file monthly reports. Further, States now have the option to choose to apply retrospective budgeting to any one or more of the categories to whom the reporting requirement applies.

AFDC BENEFITS UNDER THE UNEMPLOYED PARENTS PROGRAM

The original Social Security Act permitted States to give AFDC *only to needy children in one-parent homes, unless the second* parent was incapacitated. Then, as now, most AFDC children lived in fatherless homes. For the first 25 years of the program, if a father lost his job and his family became needy, State AFDC programs were forbidden to help the family so long as the father lived at home. In 1961, in an antirecession measure, the law was changed so that families with jobless fathers at home could qualify for AFDC. Since May of that year States were permitted to give AFDC to needy children of unemployed parents.

Effective October 1, 1990, all States that operate AFDC programs are required to provide AFDC to two-parent families who are needy because of the unemployment of the principal wage earner. (The requirement does not take effect until October 1, 1992, for American Samoa, Puerto Rico, Guam, and the Virgin Islands). The requirement is repealed September 30, 1998.

States that had an AFDC-UP program as of September 26, 1988, are required to continue operating the program without any time limit on eligibility. Other States have the option to impose such a time limit. In exercising this option, a State may not deny AFDC to a family unless the family has received AFDC under the unemployed parents program in at least 6 of the preceding 12 months. Thus, a State may deny benefits to a family for 7 out of every 13 months. As of January 1991, the following are the States which have time limits on eligibility and the maximum number of months in any 13-month period that an applicant can be denied benefits: Arizona (1), Arkansas (6), Colorado (4), Florida (6), Georgia (6), Idaho (6), Louisiana (6), Nevada (1), Oklahoma (6), South Dakota (7), Texas (6), Virginia (6), Utah (7), and Wyoming (7).

Like other AFDC families, families receiving AFDC cash assistance in the unemployed parents program are automatically eligible for Medicaid. The Family Support Act of 1988 requires States electing time-limited benefits to provide Medicaid to all members of the family without any time limitation.

At the inception of the AFDC-UP program, States defined "unemployment," and some included in the program families in which the principal wage earner worked as much as 35 hours a week. Since 1971, Federal regulations have specified that an AFDC parent must work fewer than 100 hours in a month to be classified as unemployed, unless hours are of a temporary nature for intermittent work and the individual met the 100-hour rule in the two preceding months and is expected to meet it the following month. The Family Support Act of 1988 authorizes eight State or local demonstrations to test a definition of unemployment that is easier to meet than the present 100-hour rule, including (if any State or locality so requests) at least one demonstration that tests the elimination of the 100-hour rule or any other Federal durational standard. Projects are currently underway in California, Wisconsin, and Utah to demonstrate and evaluate alternative definitions of unemployment.

Attachment to the labor force is one condition of eligibility for AFDC-UP. The principal earner must: (1) have 6 or more quarters of work in any 13-calendar-quarter period ending within 1 year prior to application for assistance; or (2) have received or been eligible to receive unemployment compensation within 1 year prior to application for assistance. A quarter of work is a quarter in which an individual earns at least $50 or in which the individual participated in the JOBS program. At State option, attendance in elementary or secondary school, vocational or technical training, or participation in JTPA, may be substituted for up to 4 of the 6 required quarters of work. Participation in the WIN program and CWEP prior to October 1990 also count toward the quarter of work requirement.

JOB OPPORTUNITIES AND BASIC SKILLS (JOBS) TRAINING PROGRAM AND SUPPORTIVE SERVICES

The Family Support Act of 1988 established a new employment, education and training program for recipients of AFDC. This new program, called the job opportunities and basic skills (JOBS) training program, replaces the work incentive (WIN) program and other provisions of prior law.

Purpose and administration

The purpose of the JOBS program is to assure that needy families with children obtain the education, training and employment that will help them avoid long-term welfare dependence. Each State is required to have a JOBS program, under a State plan approved by the Secretary of the Department of Health and Human Services (HHS). States were required to implement the program no later than October 1, 1990. No later than October 1, 1992, the program must be available in every subdivision of the State where it is feasible to operate the program. Table 2 provides information on JOBS programs in the States, based on JOBS State plans as of January 1991. As the first column of the table shows, all 50 States, the District of Columbia, and the territories (Guam, Puerto Rico and the Virgin Islands) met the implementation date requirement for JOBS, and many implemented the program early. The table also shows that, as of January 1991, 31 States, the District of Columbia, and the territories are implementing the program statewide.

The JOBS program is administered at the Federal level by a new Assistant Secretary of HHS, and at the State level by the State welfare agency. The State welfare agency may offer services and activities directly, or through arrangements or contracts with Job Training Partnership Act (JTPA) administrative entities, State and local educational agencies and with other public agencies or private organizations (including community-based organizations).

Assessment, employability plan, case management, and orientation

The State must make an initial assessment of the education, child care and other supportive service needs as well as the skills, prior work experience, and employability of each JOBS participant, and, on the basis of the assessment, develop an employability plan for the participant. The State agency may require the participant to enter into an agreement with the State that specifies the participant's obligations under the program, and the activities and services to be provided by the State. Table 2 shows that, as of January 1991, 10 States and the Virgin Islands chose to require such an agreement.

The State agency may assign a case manager to each participant and the participant's family. The case manager must be responsible for assisting the family to obtain needed services to ensure effective participation in the JOBS program. Table 2 shows that only 3 States—Iowa, Oklahoma and West Virginia—chose not to assign a case manager.

The State agency is required to provide certain information about the JOBS program and supportive services to applicants and recipients. For example, the agency must inform applicants and recipients of AFDC of the opportunities for which they are eligible under the JOBS program, the obligation of the State agency, and the rights, responsibilities and obligations of participants. The agency must provide detailed information about day care services and must inform applicants and recipients of all other supportive services, including transitional health care benefits (see separate section on supportive services).

Services and activities

A range of services and activities must be offered by each State under the JOBS program; however, States are not required to operate the JOBS program uniformly in all parts of the State. The services and activities a State must offer include: (1) education activities, including high school or equivalent education, basic and remedial education to achieve a basic literacy level, and education for individuals with limited English proficiency; (2) job skills training; (3) job readiness activities; (4) job development and job placement; and (5) supportive services (see separate section on supportive services).

States are required to offer two of the following four activities: (1) group and individual job search; (2) on-the-job training; (3) work supplementation programs; and (4) community work experience (CWEP) programs or any other work experience program approved by the Secretary. In addition to these activities, States may also offer postsecondary education to JOBS participants. Table 2 shows which of these activities the individual States are offering, as of January 1991.

When an individual age 20 or over who does not have a high school diploma (or equivalent) is required to participate in the JOBS program, the State agency must include education services as a component unless (1) the individual demonstrates a basic literacy level, or (2) the employability plan identifies a long-term employment goal that does not require a high school diploma.

Following is a more detailed discussion of the Federal requirements for job search, CWEP, and work supplementation programs.

Job search.—States may require AFDC applicants and recipients to participate in a job search program beginning at the time of application. States may require up to 8 weeks of job search for applicants, and may, in addition, require up to 8 weeks of job search for AFDC recipients each year. This means that in the first year, up to 16 weeks of job search may be required, with 8 weeks per year thereafter. Additional job search activities may not be required by the State of an individual unless they are in combination with some other education, training or employment activity which is designed to improve the individual's prospects for employment. In no event may a State require an AFDC recipient to participate in more than 3 weeks of job search before the State conducts an employability assessment for that recipient. Finally, job search cannot be treated for any purpose as an activity under the JOBS program if an individual has participated in job search for 4 out of the preceding 12 months.

Community work experience.—The purpose of a CWEP program is to provide experience and training for individuals not otherwise able to obtain employment. CWEP programs must be designed to improve the employability of participants through actual work experience and training and to enable individuals employed under CWEP programs to move into regular employment. CWEP programs must be limited to projects which serve a useful, public purpose in fields such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety and day care.

A State electing to operate a CWEP program must ensure that the maximum number of hours that any individual may be required to work under the CWEP program is no greater than the number of hours derived by dividing the total AFDC benefit by the Federal minimum wage (or, if greater, the State minimum wage). Any AFDC benefit amount for which the State receives reimbursement through child support collection cannot be taken into account in determining the maximum number of hours that individuals may be required to work.

After an individual has been assigned to a CWEP position for 9 months, the individual cannot be required to continue in that assignment unless the maximum number of hours of work is no greater than the cash benefit (excluding child support) divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

At the conclusion of each CWEP assignment, but, in any event, after each 6 months of participation in CWEP, the State agency must provide a reassessment, and revision, as appropriate, of the individual's employability plan.

Work supplementation.—Under a work supplementation program, a State reserves the amount that would have been payable to an AFDC family and uses the amount instead to provide and subsidize a job for the family. Recipients may be placed in jobs offered by private as well as nonprofit employers. The work supplementation is an alternative to an AFDC payment. Under JOBS, States may make work supplementation either mandatory or voluntary, and States are required to provide Medicaid to work supplementation participants.

States operating a work supplementation program may adjust the level of their AFDC standard of need in order to carry out the program, and need standards may vary from one area of the State to another. Need standards may also vary among recipient categories, to the extent that the State determines the variation to be appropriate on the basis of the ability of the recipient to participate in the work supplementation program. States are able to make further adjustments to amounts paid to different categories of AFDC recipients participating in work supplementation in order to offset increases in benefits from non-AFDC means-tested programs.

States are permitted to reduce or eliminate the amount of earned income disregards for families participating in a work supplementation program, and are permitted to offer the $30 plus one-third earned income disregard for up to 9 months for participants.

Federal funding under the program is limited for each participant to the aggregate of 9 months worth of the maximum AFDC grant (unreduced by earned income disregards or changes to the need standard) the participant family otherwise would have received were it not participating in the work supplementation program and had no income (or less if the person participates for fewer than 9 months).

Participation requirements

To the extent resources are available, a State must require nonexempt AFDC recipients to participate in the JOBS program. Exempt applicants and recipients may participate on a voluntary basis. Exempt recipients would be those who are: (1) ill, incapacitated, or of advanced age; (2) needed in the home because of the illness or incapacity of another family member (who need not be a member of the AFDC unit); (3) the parent or other relative of a child under age 3 who is personally providing care for the child (or, if provided in the State plan, any age that is less than 3 but not less than 1); (4) employed 30 or more hours a week; (5) a child under age 16 or attending, full time, an elementary, secondary or vocational school; (6) a woman who is in at least the second trimester of pregnancy; or (7) residing in an area where the program is not available. Table 2 shows that most States exempt recipients with a child under age 3 who are providing care for the child.

The 1988 law includes certain limitations on participation. The parent of a child under age 6 (but older than the age for an exemption) who is personally providing care for the child may be required to participate only if child care is guaranteed and required participation is limited to no more than 20 hours per week. In the case of an AFDC-UP family, the exemption relating to age of child may apply to only one parent, except that the State may require both parents to participate if child care is guaranteed.

There are certain special requirements under JOBS related to education. To the extent the JOBS program is available and State resources permit, a State must require a custodial parent under age 20 who has not completed high school (or the equivalent), including a parent who is not otherwise required to participate in JOBS solely because of the exclusion relating to providing care for a young child, to participate in an educational activity. Even though such a parent is providing care for a child under 6 years of age, the State agency may require the parent to participate in the educational activity on a full-time basis. Alternative work or training activities may be provided if the parent fails to make progress in an educational activity, or if an educational assessment determines that participation in an educational activity is inappropriate. Participation in alternative activities is limited to 20 hours per week.

If an individual is attending school or a course of vocational training, not less than half time, at the time he or she would otherwise begin to participate in the JOBS program, and making satisfactory progress, the attendance may meet the participation requirement for the individual, but the costs of the school or training are not eligible for Federal reimbursement.

Certain minimum participation standards are established for fiscal years 1990 through 1995 for the basic AFDC caseload. In fiscal year 1990, at least 7 percent of the nonexempt caseload in each State must participate in the JOBS program in any month. The minimum participation rates in subsequent years are 7 percent in fiscal year 1991, 11 percent in fiscal years 1992–1993, 15 percent in fiscal year 1994, and 20 percent in fiscal year 1995.

At least one parent in each AFDC–UP family must participate at least 16 hours a week in a work activity, but, with respect to CWEP, not more hours than the minimum wage equivalent based on the welfare payment less the portion of the payment reimbursed to the State by child support. Participation must be in work supplementation, community work experience or other work experience program, on-the-job training, or a State-designed work program approved by the Secretary. The percentage of AFDC–UP families required to meet this work requirement is 40 percent in fiscal year 1994, 50 percent in fiscal year 1995, 60 percent in fiscal year 1996, and 75 percent in fiscal year 1997 and fiscal year 1998 (calculated so that, on average, these percentages of the caseload would be participating in each month of the year). A State may substitute participation in an educational program in the case of a parent under age 25 who has not completed high school.

Targeting of JOBS funds

As described in detail later, Federal matching for JOBS program costs is available as a capped entitlement. The JOBS program includes incentives for States to target funds toward certain populations. States face a reduced Federal match unless 55 percent of JOBS funds is spent on the following populations: (1) families in which the custodial parent is under age 24 and has not completed high school or has little or no work experience in the preceding year; (2) families in which the youngest child is within 2 years of being ineligible for assistance because of age; (3) families who have received assistance for 36 or more months during the preceding 60-month period; and (4) applicants who have received AFDC for any 36 of the 60 months immediately preceding application. Volunteers must be given first consideration within target groups.

TABLE 2.—SUMMARY OF JOBS PROGRAMS FROM STATE PLANS AS OF JANUARY 1991

State and implementation date	Name of program; S = State administered C = County administered	Statewide	Optional components	Exemption if child under age—	Allow postsecondary education? limits?	Assign case-manager?	Require agency participant contract?
Alabama, April 1990	JOBS, C	No; 13 counties	Job search, alternative work experience.	3	Yes	Yes	No.
Alaska, October 1990	JOBS, S	Yes	Job search, alternative work experience, OJT.	3	Yes	Yes	No.
Arizona, October 1990	JOBS, S	No	Job search, OJT, CWEP	3	Yes	Yes	No.
Arkansas, July 1989	Project Success, S	Yes	Job search, OJT	1	Yes; 24 months	Yes	No.
California, July 1989	Gain, C	Yes	Job search, OJT, work supp., CWEP.	3	Yes; up to 2 years	Yes	No.
Colorado, January 1990	New Directions, C	No; 28 counties	Job search, OJT, work supp., CWEP.	1	Yes; 24 months	Yes	No.
Connecticut, July 1989	JOBS, S	Yes	Job search, OJT	3	Yes; 2 years, 3 for certified programs.	Yes	No.
Delaware, October 1989	First Step, S	Yes	Job search, OJT, CWEP	3	Yes	Yes	No.
District of Columbia, April 1990.	JOBS, S	Yes	Job search, OJT, alternative work experience.	3	Yes; up to 2 years	Yes	No.
Florida, October 1989	Project Independence, S	Yes	Job search, OJT, work supp., CWEP, alternative work experience.	3	Yes; 2 years	Yes	No.
Georgia, July 1989	Peach, C	No; 33 counties	Job search, OJT, work supp., CWEP.	3	Yes; support services provided.	Yes	Yes.
Guam, October 1990	JOBS, S	Yes	Job search,	3	Yes	Yes	No.
Hawaii, October 1990	JOBS, S	No	Job search, OJT, CWEP, alternative work experience, alternative education program.	3	Yes	Yes	No.
Idaho, October 1990	JOBS, S	No	Job search, OJT, alternative work experience.	3	Yes; 4 year limit	Yes	No.

TABLE 2.—SUMMARY OF JOBS PROGRAMS FROM STATE PLANS AS OF JANUARY 1991—Continued

State and implementation date	Name of program; S = State administered C = County administered	Statewide	Optional components	Exemption if child under age—	Allow postsecondary education? limits?	Assign case-manager?	Require agency participant contract?
Illinois, April 1990	Project Chance, S	Yes	Job search, work supp., OJT, CWEP.	3	Yes	Yes	No.
Indiana, October 1990	JOBS, S	No	Job search, OJT, CWEP	3	No	Yes	No.
Iowa, July 1989	Promise JOBS, S	Yes	Job search, CWEP, alternative work experience.	3	Yes; 30 months for 2 year degree program; 40 months for 3 or 4 year programs.	No	No.
Kansas, October 1989	KanWork/JOBS, S	Yes; KanWork in 4 counties; JOBS in balance of State.	Job search, OJT, CWEP	3	Yes; up to BA/BS	Yes	No.
Kentucky, October 1990	JOBS, S	No; 18 counties	Job search, OJT, CWEP	3	Yes; limited to 3 yrs. 6 semesters for 2 yr degree program; 8 (or 9 with good cause) for 4 yr program.	Yes	No.
Louisiana, October 1990	JOBS, S	No; 10 parishes	Job search, OJT	3	Yes; up to 2 years	Yes	Yes.
Maine, October 1990	ASPIRE/JOBS, S	Yes	Job search, OJT	3	Yes	Yes	Yes.
Maryland, July 1989	Project Independence, C	Yes	Job search, OJT, alternative work experience.	3	Yes	Yes	No.
Massachusetts, July 1989	ET, S	Yes	Job search, OJT, work supp	3	Yes	Yes	No.
Michigan, July 1989	Most, S	Yes	Job search, OJT, CWEP, work supp.	1	No	Yes	No.
Minnesota, July 1989	Stride, C	Yes	Job search, OJT, CWEP, work supp.	3	Yes; up to 4 yrs	Yes	Yes.

Mississippi, October 1990	JOBS, S	No; 9 counties	Job search, alternative work experience, OJT, CWEP.	3	Yes	Yes	No.
Missouri, July 1990	Futures, S	No; 12 counties and 1 metro.	Job search, OJT	3	Yes	Yes	No.
Montana, July 1990	JOBS, C	No; 5 counties	Job search, OJT, CWEP, work supp.	3	Yes; support services only	Yes	Yes.
Nebraska, October 1989	Job Support, S	Yes	Job search, OJT, CWEP	1	Yes; one BA/BS degree	Yes	Yes.
Nevada, July 1989	JOBS, S	No; 3 counties	Job search, OJT, CWEP	3	No	Yes	Yes.
New Hampshire, October 1989.	JOBS, S	Yes	Job search, OJT	3	Yes; up to 2 yrs	Yes	No.
New Jersey, July 1989	Reach, C	Yes	Job search, OJT, work supp., CWEP.	2	Yes	Yes	No.
New Mexico, January 1990.	Project Forward, S	Yes	Job search, OJT, CWEP, alternative work experience, entrepreneurship.	3	Yes	Yes	No.
New York, October 1990	JOBS, C	Yes	Job search, OJT, work supp., CWEP.	3	Yes; 2 years	Yes	No.
North Carolina, October 1990.	JOBS, C	No	Job search, OJT, CWEP	3	Yes	Yes	No.
North Dakota, April 1990	JOBS, C	Yes	Job search, OJT, work supp., CWEP.	3	Yes; max degree is BA (up to 4 yrs training), no training after degree.	Yes	No.
Ohio, July 1989	JOBS, C	70 counties	Job search, OJT, work supp., CWEP.	1	Yes	Yes	No.
Oklahoma, July 1989	JOBS, S	Yes	Job search, OJT, alternative work experience.	1	Yes	No	No.
Oregon, October 1990	JOBS, S	No	Job search, OJT, work supp	3	No	Yes	No.
Pennsylvania, October 1989.	New Directions, S	Yes	Job search, OJT, CWEP	3	Yes	Yes	No.
Puerto Rico, October 1990.	Pasos, S	Yes	Job search, OJT, alternative work experience.	3	Yes; up to 2 years	Yes	No.
Rhode Island, July 1989	Pathways to Independence, S.	Yes	Job search, OJT, work supp	3	Yes; none stated	Yes	No.

TABLE 2.—SUMMARY OF JOBS PROGRAMS FROM STATE PLANS AS OF JANUARY 1991—Continued

State and implementation date	Name of program; S = State administered C = County administered	Statewide	Optional components	Exemption if child under age—	Allow postsecondary education? limits?	Assign case-manager?	Require agency partici-pant contract?
South Carolina, October 1989.	Work Support Services Program, C.	No	Job search, OJT, work experience (no CWEP).	3	Yes; up to 2 years	Yes	No.
South Dakota, October 1989.	JOBS, S	Yes	Job search, OJT, CWEP	3	Yes	Yes	No.
Tennessee, October 1990	JOBS, S	Yes	Job search, OJT	3	Yes	Yes	No.
Texas, October 1990	JOBS, S	No	Job search, OJT, alternative work experience.	3	Yes; up to 2 years	Yes	No.
Utah, October 1989	Self-sufficiency, S	Yes	Job search, OJT	3	Yes	Yes	Yes.
Vermont, October 1990	Reach Up, S	Yes	Job search, OJT, work supp., CWEP.	3	Yes	Yes	No.
Virgin Islands, April 1990	JOBS/Hope, S	Yes	Job search, OJT, CWEP	2	Yes	Yes	Yes.
Virginia, October 1990	JOBS, C	Yes	Job search, OJT, alternative work experience.	3	Yes; up to 2 years	Yes	No.
Washington, October 1990.	JOBS, [in non-FIP area] S	Yes [in non-FIP areas].	Job search, OJT, work supp., CWEP, alternative work experience.	3	Yes	Yes	No.
West Virginia, October 1989.	JOBS, S	Yes	Job search, OJT, CWEP	3	Yes; 2 years with exceptions.	No	No.
Wisconsin, July 1989	WEJT/JOBS, C	Yes	Job search, OJT, work supp., CWEP.	2	Yes	Yes	Yes.
Wyoming, July 1990	WOW, S	No	Job search, OJT, alternative work experience.	3	Yes; up to 4 yrs; first BA/BS only.	Yes	Yes.

Source: Family Support Administration, HHS.

Supportive and transitional services

State agencies must guarantee child care for a recipient if the care is necessary for the individual to work. In addition, the State must guarantee child care for education and training activities, including participation in the JOBS program, if the State approves the activity and determines that the individual is participating satisfactorily.

The agency may provide the care itself, arrange care by use of contracts or vouchers, provide cash or vouchers in advance, reimburse the family, or adopt other arrangements. Regardless of the method, reimbursement may not be less than the amount of the AFDC child care disregard, which is equal to the lower of (1) actual costs or (2) $175 per month per child over age 2 and $200 per month per child under age 2. Federal financial participation is available for the actual cost of child care up to a statewide limit established by the State welfare agency in its State supportive services plan, but not for more than the applicable local market rate. The child care must meet applicable standards of State and local law and the entity providing care must allow parental access.

The Federal matching rate for supportive child care is the Medicaid matching rate and is available as an open-ended entitlement.

The State agency must also guarantee child care to the extent the care is necessary for an individual's employment in any case where a family has ceased to receive AFDC assistance as a result of increased hours of, or increased income from, employment or as a result of the loss of earnings disregards. Child care provisions for transitional assistance are essentially the same as the provisions for child care received during participation in the JOBS program, except that: (1) child care is limited to a period of 12 months after the last month for which the family actually received assistance and (2) families receiving child care assistance must contribute to the cost of the care in accordance with a sliding scale formula established by the State, based on ability to pay.

The State must provide payment or reimbursement for necessary transportation and other work-related expenses, including other work-related supportive services, that the State determines are necessary to enable an individual to participate in JOBS. Federal matching is 50 percent subject to the overall JOBS funding cap (see section on Federal and State expenditures for JOBS). There is no Federal limit on the amount of reimbursement with respect to an individual.

Table 3 provides State-specific information on State options relating to child care and other supportive services, based on State plans for supportive services as of January, 1991.

TABLE 3.—SUMMARY OF OPTIONS UNDER THE SUPPORTIVE SERVICES PLANS, FROM PLANS AS OF JANUARY 1991

State	Method of providing child care during participation in work, education, or training	Method of providing transitional child care	Statewide limit on childcare [1]	Provide 90-day transitional supportive services [2]	Fill gap in supportive services [3]
Alabama	Directly, income disregard, cash reimbursement purchase of service.	Directly, cash reimbursement, purchase of service.	$200/month	No	Yes; up to one month child care if necessary.
Alaska	Purchase of service, income disregard.	Cash reimbursement, purchase of service.	$525	Yes	Yes, 2 weeks.
Arkansas	Income disregard, cash reimbursement purchase of service.	Cash reimbursement, purchase of service.	$300/250	Yes	Yes.
Arizona	Directly, cash in advance, voucher in advance, income disregard, cash reimbursement, purchase of service, other.	Cash in advance, voucher in advance, purchase of service, cash reimbursement, other.	$613.80	Yes	Yes.
California	Directly, income disregard, cash in advance, voucher in advance, cash reimbursement, purchase of service, other.	Cash in advance, voucher in advance, cash reimbursement, purchase of service, other.	$779.40; $1,075.57–handicapped.	Yes	Yes.
Colorado	Directly, income disregard, voucher in advance, cash reimbursement, purchase of service, other.	Directly, cash in advance, voucher in advance, cash reimbursement, purchase of service, other.	$525; $1,050-handicapped.	Yes	Yes.

Connecticut	Directly, income disregard, cash in advance, cash reimbursement, purchase of service.	Directly, cash in advance, cash reimbursement, purchase of service.	$325;$435-handicapped.	No	Yes; up to 1 month.
Delaware	Income, disregard, cash in advance, voucher in advance, purchase of service, other.	Cash in advance, voucher in advance, purchase of service, other.	$262.16/247.86	No	Yes; up to 1 month child care only.
District of Columbia	Income disregard, cash in advance, voucher in advance, cash reimbursement, purchase of service.	Cash in advance, voucher in advance, cash reimbursement, purchase of service.	$635.50/558	Yes	Yes; 2 weeks up to 1 month.
Florida	Income disregard, cash in advance, voucher in advance, cash reimbursement, purchase of service.	Directly, cash reimbursement, purchase of service.	$316.09/327.27	Yes	Yes.
Georgia	Purchase of service, other	Purchase of service, other	$260	Yes	Yes; 2 weeks child care only.
Guam	Cash reimbursement	Cash reimbursement	$200/190	Yes; case management only.	Yes; 2 weeks child care only.
Hawaii	Purchase of service	Cash reimbursement, other	$308	Yes	Yes; 2 weeks.
Idaho	Directly, purchase of service, other.	Cash reimbursement, purchase of service.	$264; $330/297-handicapped.	Yes	Yes.
Illinois	Directly, income disregard, cash in advance, cash reimbursement.	Purchase of service, other	$627	No	Yes; child care only.

TABLE 3.—SUMMARY OF OPTIONS UNDER THE SUPPORTIVE SERVICES PLANS, FROM PLANS AS OF JANUARY 1991—Continued

State	Method of providing child care during participation in work, education, or training	Method of providing transitional child care	Statewide limit on childcare [1]	Provide 90-day transitional supportive services [2]	Fill gap in supportive services [3]
Indiana	Directly, cash in advance, purchase of service.	Cash in advance, cash reimbursement, purchase of service.	$200/175	No	No.
Iowa	Income disregard, other	Other	$400	Yes	Yes.
Kansas	Income disregard, cash reimbursement, purchase of service.	Cash, reimbursement, purchase of service.	$336/251; $554/524-handicapped.	No	Yes; up to 1 month.
Kentucky	Directly, purchase of service	Purchase of service	$403	Yes	Yes.
Louisiana	Cash in advance, cash reimbursement, purchase of service.	Cash in advance, cash reimbursement.	$200/175	Yes	Yes; up to 1 month.
Massachusetts	Directly, income disregard, voucher in advance, purchase of service, other.	Directly, voucher in advance, cash reimbursement, purchase of service, other.	$1,294.92	No	Yes; child care only.
Maryland	Income disregard, voucher in advance, purchase of service.	Voucher in advance, cash reimbursement, purchase of service.	$328.95/268.75	Yes	Yes.
Maine	Income disregard, cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$510.62/557.92	Yes	Yes.
Michigan	Directly, cash reimbursement, purchase of service.	Other	$200/175	No	Yes; up to 2 weeks.
Minnesota					

Missouri	Income disregard, cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$200/175	Yes	Yes; 2 weeks to 1 month.
Mississippi	Cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$216/204	No	Yes.
Montana	Income disregard, purchase of service.	Purchase of service	$225.75	Yes	Yes; child care only.
Nebraska	Income disregard, cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$1000/846.30; $3000-handicapped.	No	No.
North Carolina	Directly, income disregard, cash in advance, cash reimbursement, purchase of service.	Directly, cash in advance, voucher in advance, cash reimbursement, purchase of service.	$359; $1,754-handicapped.	Yes	Yes; child care only.
North Dakota	Income disregard, cash in advance, cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$200/175	Yes	Yes; up to 1 month.
New Jersey	Income disregard, voucher in advance.	Voucher in advance	Under 2½, $738; over 2½, $574; handicapped <2½, $902; >2½, $738.	Yes	Yes; up to 2 weeks.
New Hampshire	Income disregard, cash in advance, cash reimbursement, purchase of service.	Cash in advance, cash reimbursement, purchase of service.	$422.40	No	Yes.
New Mexico	Income disregard, cash reimbursement.	Cash reimbursement	$200/175	No	No.

TABLE 3.—SUMMARY OF OPTIONS UNDER THE SUPPORTIVE SERVICES PLANS, FROM PLANS AS OF JANUARY 1991—Continued

State	Method of providing child care during participation in work, education, or training	Method of providing transitional child care	Statewide limit on childcare [1]	Provide 90-day transitional supportive services [2]	Fill gap in supportive services [3]
New York	Directly, income disregard, cash in advance, voucher in advance, cash reimbursement, purchase of service, other.	Directly, cash in advance, voucher in advance, cash reimbursement, purchase of service, other.	$883.32	Yes	Yes.
Nevada	Income disregard, cash reimbursement.	Cash reimbursement	$424/540	No	No.
Ohio	Income disregard, purchase of service.	Purchase of service	$438/471.50	Yes	Yes.
Oklahoma	Directly, voucher in advance, purchase of service.	Purchase of service	$372/341	No	Yes; child care only
Oregon	Directly	Directly	$450	Yes	Yes.
Pennsylvania					
Puerto Rico	Income disregard	Cash in advance	$125[4]	No	Yes; up to 1 month.
Rhode Island					
South Carolina	Purchase of service	Purchase of service	$426.50	Yes	Yes; up to 2 weeks.
South cakota	Directly, cash in advance	Cash in advance, cash reimbursement.	$200/175	Yes	No.
Tennessee	Income disregard, purchase of service.	Cash reimbursement, purchase of service.	$270.90/227.90	Yes	Yes.
Texas	Cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$482; $916—handicapped.	Yes	Yes.
Utah					

Virginia	Income disregard, cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$637/559	Yes	Yes.
Virgin Islands	Directly	Directly	$180[5]	Yes	No.
Vermont	Directly, cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$603.75	Yes	Yes.
Washington	Cash reimbursement, purchase of service.	Cash reimbursement, purchase of service.	$410.78; $1204—handicapped.	Yes	Yes.
Wisconsin					
West Virginia	Directly, other	Other	$310/271.25	No	Yes; up to 2 weeks.
Wyoming	Directly, purchase of service	Purchase of service	$344	No	Yes; up to 1 week.

---

[1] When 2 amounts are shown separated by a slash (/), the 1st amount is the statewide limit for children under 2. The 2nd amount is the statewide limit for children over 2. Statewide limits for handicapped children are so captioned when different limits apply.

[2] Regulations permit States to receive Federal reimbursement for up to 90 days of case management and supportive services provided to a person who has participated in the JOBS program but loses eligibility for AFDC.

[3] Regulations permit States to receive Federal reimbursement for child care and other supportive services provided to an individual who is waiting to enter a program activity or employment: (1) for a period of up to 2 weeks, or (2) for a period of up to one month where arrangements for services would otherwise be lost.

[4] This represents the highest local market rate in Puerto Rico.

[5] Represents maximum local market rate in the Virgin Islands.

INTERACTION BETWEEN AFDC AND OTHER PROGRAMS

Medicaid

States must provide Medicaid to families receiving cash assistance under AFDC. Several recent acts require that States extend this categorically needy Medicaid coverage, at regular Federal matching rates, to other groups. The most important of these groups include (1) pregnant women, and children up to age 6, with family incomes up to 133 percent of the poverty level; (2) children born on or after October 1, 1983, with family incomes below the Federal poverty level (this provision is phased in to cover all children up to age 19 by the year 2002); and (3) certain persons whose family income and resources are below the AFDC standards but who fail to qualify for AFDC for other reasons, such as family structure (these include first-time pregnant women). At their option, States may provide coverage to pregnant women and infants with incomes at or below 185 percent of the Federal poverty level.

When families lose AFDC eligibility, categorical Medicaid eligibility also frequently ends, except under those circumstances outlined above, or if the family qualifies for transitional Medicaid benefits established under Public Law 100-485, the Family Support Act of 1988, which took effect April 1, 1990. As a result of this act, States are required to extend Medicaid coverage for 12 months to families who leave cash assistance due to earnings. During the first 6 months of coverage, the States must provide each family the same Medicaid coverage that the family had while receiving AFDC. States are not permitted to impose premiums for this coverage. States do have a "Medicaid wrap-around" option, under which they may use Medicaid funds to pay a family's expenses for premiums, deductibles and coinsurance for any health care coverage offered by the employer of the caretaker relative. The employer coverage would then be treated by the Medicaid program as a third party liability.

During the second 6 months of coverage, the States have a number of options. First, they may limit the scope of the Medicaid coverage to acute care benefits, dropping nursing home coverage and other nonacute benefits. Second, States may impose a monthly premium on families with incomes, less necessary child care expenses, in excess of 100 percent of the Federal poverty level. The monthly premium on these families could not exceed 3 percent of gross income. Premiums would be determined on the basis of quarterly reports from families on earnings and child care costs. Third, States have the option of offering families the choice of (1) basic Medicaid coverage (either the same as offered to cash assistance beneficiaries or the more limited acute care package) or (2) one or more types of alternative coverage. These alternative coverages could include enrollment in an employer group health plan, a State employee plan, a State health plan for the uninsured, or a health maintenance organization. Families would always have a choice of staying with their basic Medicaid coverage, although they could not elect both the basic Medicaid and one of the alternative coverages. With respect to the basic Medicaid coverage, States would have the same "Medicaid wrap-around" option as during the first

6-month period. In general, transitional coverage would terminate if a family no longer had a child, failed to report earnings on a quarterly basis, failed to pay any required premium, or fradulently obtained cash assistance benefits.

Effective October 1, 1990, States are required to extend cash assistance benefits to two-parent families where the principal earner is unemployed (AFDC–UP). States that have an AFDC–UP program as of September 26, 1988, are required to continue operating such programs without any time limit on eligibility. Other States will have the option to limit cash assistance benefits to as few as 6 months in any 13-month period. States are required to provide full Medicaid coverage to all members of these families even in months when cash assistance benefits are not paid because of a State-established time limit.

Food stamps

Most AFDC families are also eligible for and participate in the food stamp program, which provides an important in-kind supplement to the cash assistance paid under AFDC. Although food stamp benefits are not counted in determining AFDC eligibility, the food stamp program does consider AFDC payments to be countable income and reduces the food stamp benefit by $0.30 for each dollar of countable cash income. This interaction between AFDC and the food stamp program has important financial implications for a State which desires to increase the income of its AFDC recipients. Because food stamps are reduced by $0.30 for each additional $1 of AFDC income, the State must expend $1.43 to obtain an effective $1 increase in AFDC recipients' total income. For a State with a 50 percent matching rate, the State must expend $0.72 to actually obtain a $1 increase in recipient income. This would be the typical situation for an AFDC recipient with no earnings.

Table 4 illustrates the interaction of various programs for a mother with two children at various earning levels. The example assumes the family lives in Pennsylvania. Calculations are made after the mother has been working for 4 months and lost the disregard of one-third of "residual" earnings (those remaining after subtraction of a $120 standard allowance).

TABLE 4.—EARNINGS AND BENEFITS FOR A MOTHER WITH TWO CHILDREN WITH DAYCARE EXPENSES—AFTER 4 MONTHS ON JOB (JANUARY 1991)—(PENNSYLVANIA)

Earnings	EITC [1]	AFDC [2]	Food stamps [3]	Medicaid	Taxes			Work expenses [5]	"Disposable" income
					Social security	Federal income [4]	State income		
0	0	$5,052	$2,166	Yes	0	0	0	0	[6] $7,218
$2,000	$346	4,892	1,854	Yes	$153	0	0	$600	[6] 8,339
$4,000	692	3,292	1,974	Yes	306	0	0	1,200	[6] 8,452
$5,000	865	2,492	2,034	Yes	383	0	0	1,500	[6] 8,508
$6,000	1,038	1,692	2,094	Yes	459	0	0	1,800	[6] 8,565
$7,000	1,211	892	2,154	Yes	536	0	0	2,100	[6] 8,621
$8,000	1,235	0	2,241	Yes [7]	612	0	0	2,400	[6] 8,464
$9,000	1,235	0	2,061	Yes [8]	689	0	$38	2,700	[6] 8,869
$10,000	1,235	0	1,881	No [8]	765	0	210	3,000	[6] 9,141
$15,000	772	0	0	No [9]	1,148	0	315	4,200	10,109
$20,000	154	0	0	No	1,530	$283	420	5,200	12,721
$30,000	0	0	0	No	2,295	1,943	630	5,400	19,732
$50,000	0	0	0	No	3,825	6,405	1,050	5,400	33,320

[1] Assumes that both children are over age 1. If one were younger, EITC would be larger (maximum of $1,592 at earnings of $8,000–$10,000).

[2] Assumes these deductions: $120 monthly standard allowance (which would drop to $90 after 1 year on the job) and child care costs equal to 20 percent of earnings, up to maximum of $350 for 2 children.

[3] Assumes these deductions: 20 percent of earnings, $116 monthly standard deduction and child care costs equal to 20 percent of wages, up to maximum of $320 for 2 children.

[4] Head of household rates in effect for 1991. The dependent care tax credit reduces tax liability at earnings of $15,000 and above.

[5] Assumed to equal 10 percent of earnings up to maximum of $100 monthly, plus child care costs equal to 20 percent of earnings up to the maximum allowed by AFDC ($350 for 2 children).

[6] In addition, the benefits from Medicaid could be added, but are not. In Pennsylvania, the cost of Medicaid for a 3-person AFDC family averaged about $2,304 in fiscal year 1989.

[7] Family would qualify for Medicaid because the mother, by law, would be deemed still an AFDC recipient, even though no AFDC would be paid; her calculated benefit would be below the minimum amount ($10 monthly) payable.

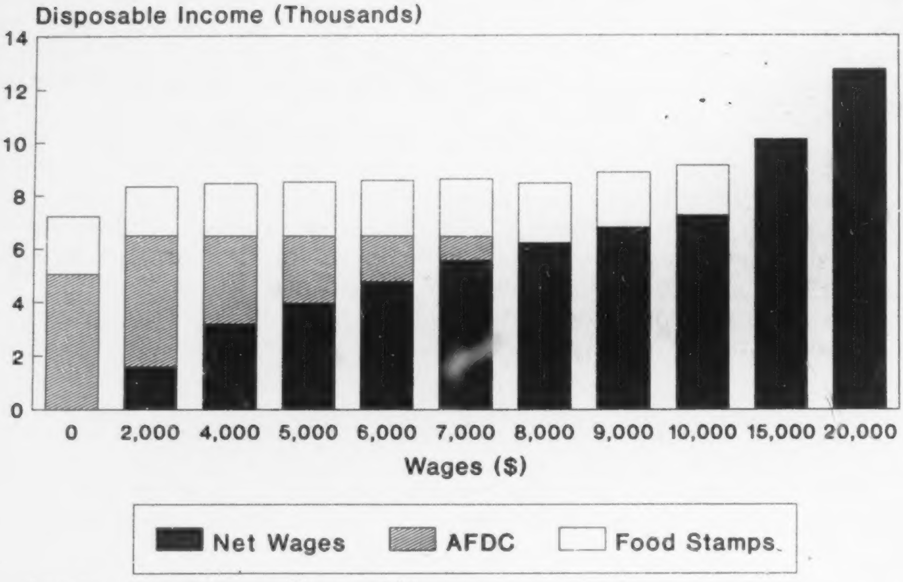
[8] Family would qualify for Medicaid for 12 months after leaving AFDC under the 1988 Family Support Act. State must offer Medicaid to all children up to age 6 whose family income is not above 133 percent of the Federal poverty guideline (ceiling of $14,850 for a family of 3 in 1991) and to children over age 6 born after September 1, 1983 (up to age 7⅓ in January 1991), whose family income is below the poverty guideline ($11,140 for a family of 3).

[9] After losing her Medicaid transitional benefits, to regain eligibility, mother must spend down on medical expenses to State's medically needy income limit ($5,400 in September 1989).

Note: Under IRS rules, unless earnings at least equal AFDC, the mother generally is not a "head of household" eligible for EITC; but it appears that this rule is rarely applied. Example assumes the rule is not applied.

Source: Congressional Research Service.

CHART 1. DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A FAMILY OF THREE WITH CHILD CARE EXPENSES, PENNSYLVANIA, JANUARY 1991



Source: Committee on Ways and Means

Child support enforcement

Federal law requires AFDC families (and applicants), as a condition of eligibility for aid, to assign their support rights to the State, to cooperate with the State in establishing the paternity of a child born outside of marriage, and to cooperate with the State in obtaining support payments. Families receiving AFDC benefits automatically qualify (free of charge) for CSE services. Their cases are referred to the CSE agency. The provision requiring the AFDC applicant or recipient to assign to the State her rights to support covers both current support and any arrears which have accrued, and lasts as long as the family receives AFDC. When the family no longer receives AFDC, the mother or caretaker relative regains her right to collect support, but if there are arrears, the State may claim those arrears up to the amount paid out as AFDC benefits.

Child support payments made on behalf of a child receiving AFDC are supposed to be paid to the CSE agency rather than directly to the family. If the child support collection is insufficient to disqualify the family from receiving AFDC payments, the family receives its full monthly AFDC grant plus (pursuant to the 1984 Deficit Reduction Act) the first $50 of the child support payment made in the child's behalf for that month. In several States where the payment standard exceeds the maximum payment (Georgia, Maine, Mississippi, Wyoming, South Carolina, Tennessee, and Virginia), additional amounts of child support are disregarded. The remainder of that monthly child support payment is distributed to reimburse the State and Federal Governments in proportion to their assistance to the family. If the family's income, including the child support payment, is sufficient to make the family ineligible for AFDC payments, the family's AFDC benefits are ended, and future child support payments are paid directly from the noncustodial parent to the family.

SSI and Social Security

In AFDC, Social Security benefits are treated as unearned income and thus AFDC benefits are reduced by $1 for each $1 of OASDI benefits. SSI benefits received by a potential member of an AFDC family are treated differently. This member (both a child or an adult receiving SSI benefits) is not regarded as a part of the AFDC unit. Thus his needs are not taken into account in determining the AFDC benefit level. At the same time, the income and resources of the SSI recipient are also ignored in determining the AFDC benefit.

AFDC EMERGENCY ASSISTANCE

The Social Security Act permits States, at their option, to operate an Emergency Assistance program for needy families with children (whether or not eligible for AFDC) if the assistance is necessary to avoid the destitution of the child or to provide living arrangements in a home for the child. The statute authorizes 50 percent Federal matching for emergency assistance furnished for a period not in excess of 30 days in any 12-month period. Regulations state that Federal matching is available for emergency assistance authorized by the State during one period of 30 consecutive days in any 12 consecutive months, including payments which are to meet needs which arose before the 30-day period or are for such needs as rent which extend beyond the 30-day period.

In fiscal year 1990, 32 jurisdictions operated an Emergency Assistance program. Table 5 presents the average monthly caseload and total fiscal year payments for jurisdictions participating in the program. Table 6 provides historical data on total payments.

Note that AFDC regulations also allow States to include in their State standards of need provision for meeting "special needs" of AFDC applicants and recipients. The State plan must specify the circumstances under which payments will be made for special needs.

During the mid 1980s, some States began using AFDC special needs funds and/or emergency assistance funds to house otherwise homeless families in hotels. Moreover, a few States were found to be using emergency assistance (EA) funds for more than the 30-day limit specified in law. Placement of a family in a hotel, a last resort that costs an average of more than $1,000 a month, has been controversial, and several reports have found dangerous and squalid conditions in some such "welfare hotels."

In response, DHHS issued a proposed rule (published in the Federal Register on December 14, 1987) restricting use of AFDC-special needs for housing expenses, and reconfirming the 30-day limit on EA expenditures. The DHHS proposed regulation would have (1) established an "unambiguous" time limit on the use of EA funds and (2) prohibited States from adopting, either as a special or basic need, an AFDC shelter allowance that varied by type of residence (e.g., apartment or hotel). On December 22, 1987, Congress passed legislation that prohibited, until October 1, 1988, the DHHS from taking any action on the proposed EA and AFDC-special needs regulations. The moratorium on promulgation of the regulation was intended to give Congress an opportunity to determine whether and how the current AFDC statute should be amended to respond to the problems of homeless families. The Stewart B. McKinney Homeless Assistance Amendments Act of 1988 extended the moratorium until October 1, 1989, and required DHHS to issue a report on recommendations for statutory and regulatory changes in AFDC-special needs and the EA program with respect to the emergency needs of AFDC-eligible families. The report was sent to Congress July 3, 1989, with a proposal to issue a final regulation which would prohibit reimbursement under the EA program for assistance for periods beyond 30 consecutive days in a 12-month period (while continuing to allow EA funds for past-due rent and utility costs and for first month's rent and security deposit). The proposal also would delete from the Department's previously proposed rule the provision precluding States from establishing AFDC shelter allowances that vary by type of residence. In addition, the report stated that the Department would develop legislative proposals to prohibit the use of Federal AFDC and EA matching funds for welfare hotels. The 1989 OBRA prohibited the Secretary from implementing any final EA or AFDC-special need regulations before October 1, 1990. The 1990 OBRA extended this prohibition until October 1, 1991.

TABLE 5.—EMERGENCY ASSISTANCE: TOTAL CASELOAD AND PAYMENTS (FEDERAL AND STATE) FISCAL YEAR 1990

State	Average monthly caseload	Total fiscal year payments
California	416	$43,173,215
Delaware	202	420,337
District of Columbia	1,747	191,475
Florida	2,103	8,827,159
Georgia	1,704	5,898,283
Illinois	1,577	3,221,120
Kansas	145	519,928
Maine	289	1,183,823
Maryland	2,065	5,060,128
Massachusetts	5,336	54,927,078
Michigan	5,656	19,950,634
Minnesota	1,847	10,409,507
Montana	60	162,487
Nebraska	253	1,641,164
Nevada	41	176,847
New Hampshire	36	372,780
New Jersey	3,827	39,835,184
New York	([1])	58,680,826
North Carolina	1,480	3,536,394
Ohio	4,315	4,484,397
Oklahoma	2,220	4,375,824
Oregon	1,758	4,872,589
Pennsylvania	1,512	4,704,539
Puerto Rico	211	83,001
Utah	100	257,193
Vermont	395	1,351,039
Virgin Islands	([1])	4,131
Virginia	519	57,332
Washington	511	1,938,192
West Virginia	1,229	1,473,737
Wisconsin	884	2,436,897
Wyoming	196	481,627
U.S. total	42,634	284,708,867

[1] Not reported.

Source: Family Support Administration (financial data: FSA-231; caseload: FSA-3645).

TABLE 6.—TOTAL FEDERAL AND STATE PAYMENTS UNDER THE EMERGENCY ASSISTANCE PROGRAM, SELECTED FISCAL YEARS 1970–90

[In millions]

	Amount
Fiscal year:	
1970	$14
1975	70
1980	109
1985	157
1986	175
1987	203
1988	256
1989	310
1990	285

Source: Office of Financial Management, Family Support Administration.

CHILD CARE FOR FAMILIES AT RISK OF AFDC RECEIPT

The Omnibus Budget Reconciliation Act of 1990 increased funding for the existing AFDC child care program to provide $300 million for fiscal year 1991 and thereafter to the States to provide child care services to low-income, non-AFDC families that (1) need such care in order to work and (2) would otherwise be at risk of becoming eligible for AFDC.

Capped entitlement funds would be allocated on the basis of child population. Rules relating to Federal matching rates, reimbursement, standards and fee schedules would match the same rules as apply for child care for AFDC families, except that all child care providers that receive funds must be licensed, regulated, or registered.

AFDC BENEFIT LEVELS AND TRENDS

Each State establishes a "need standard" (the income the State decides is essential for basic consumption items) and a "payment standard" (100 percent or less of the need level). Benefits are generally computed by subtracting countable income from the State's payment standard.

Maximum payments

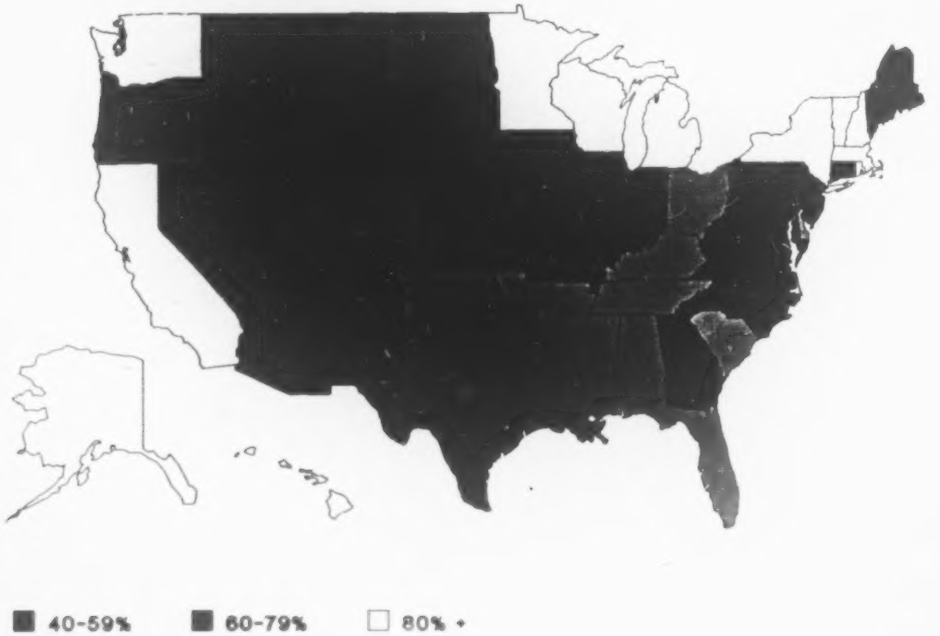
Maximum AFDC payments vary sharply from State to State, as shown by tables 7 and 8. State payments for AFDC families of three with no countable income in January 1991 ranged from $120 in Mississippi to $891 in Alaska. Table 7 presents the gross income limit, the need standard, and the maximum monthly potential AFDC and food stamp benefits for a one-parent family of three persons, as of January 1991.

The food stamp benefits are calculated by deducting from the family's AFDC benefit (the only cash income of the family) the maximum deductions allowed under food stamps for a nonaged, nondisabled family: a total of $302. This consists of a standard deduction of $116, given in all households, plus a deduction of $186 for excess shelter costs.

If the family qualified only for the standard deduction, its food stamp benefits would be cut in most States by about $55. Table 7 shows combined maximum potential benefits of $629 to an Illinois AFDC family of 3, including $262 in food stamps. The same family would receive only $574 in combined benefits, including $207 in food stamps, if it were credited only with the standard deduction. Food stamp program data show that most AFDC families do qualify for a deduction of some shelter costs.

As table 10 illustrates, during 1990, 24 States increased AFDC payments. Fifteen increased benefits by $11 or more per month. Thirty jurisdictions had no payment increases. As a result of the increases, the median State benefit for a family of three increased from $364 to $367 per month in nominal dollars. Since January 1991, several States have reduced, or indicated that they plan to reduce, AFDC benefits.

CHART 2. MAXIMUM COMBINED AFDC AND FOOD STAMP BENEFIT AS A PERCENT OF POVERTY, FOR A ONE-PARENT FAMILY OF THREE, JANUARY 1991*



* Combined family benefit in 1/90 as a percent of the 1990 poverty threshold for a family of three.

Note: The combined AFDC/food stamp benefit equals 77 percent of the poverty threshold in the District of Columbia.

TABLE 7.—GROSS INCOME LIMIT, NEED STANDARD, AND MAXIMUM MONTHLY POTENTIAL BENEFITS, AFDC AND FOOD STAMPS, ONE-PARENT FAMILY [1] OF THREE PERSONS, JANUARY 1991

State	Gross income limit (185 percent of need standard)	100 percent of "need"	Maximum AFDC grant [2]	Food stamp benefit [3]	Combined benefits	Combined benefits as a percent of 1990 poverty threshold [4]	AFDC benefits as a percent of 1990 poverty threshold [4]
Alabama	$1,116	$603	$124	$277	$401	46	14
Alaska	1,648	891	891	250	1,141	105	82
Arizona	1,149	621	293	277	570	66	34
Arkansas	1,304	705	204	277	481	55	24
California	1,284	694	694	159	853	98	80
Colorado	779	421	356	260	616	71	41
Connecticut	1,258	680	680	163	843	97	78
Delaware	625	338	338	266	604	70	39
District of Columbia	1,317	712	428	239	667	77	49
Florida	1,628	880	294	277	571	66	34
Georgia	784	424	280	277	557	64	32
Hawaii	1,872	1,012	632	391	1,023	103	63
Idaho	1,025	554	317	272	589	68	37
Illinois	1,500	811	[5] 367	262	629	72	42
Indiana	592	320	288	277	565	65	33
Iowa	919	497	426	239	665	77	49
Kansas	757	409	[5] 409	255	664	77	47
Kentucky	973	526	228	277	505	58	26
Louisiana	1,217	658	190	277	467	54	22
Maine	1,206	652	453	231	684	79	52
Maryland	1,040	562	[5] 406	263	669	77	47
Massachusetts	997	539	539	205	744	86	62
Michigan (Washtenaw County)	1,151	622	[5] 555	223	778	90	64
Michigan (Wayne County)	1,084	586	[5] 525	232	757	87	60
Minnesota	984	532	532	208	740	85	61
Mississippi	681	368	120	277	397	46	14
Missouri	577	312	292	277	569	66	34
Montana	838	453	370	256	626	72	43
Nebraska	673	364	364	258	622	72	42
Nevada	1,018	550	330	268	598	69	38
New Hampshire	955	516	516	212	728	84	59
New Jersey	784	424	[5] 424	247	671	77	49

TABLE 7.—GROSS INCOME LIMIT, NEED STANDARD, AND MAXIMUM MONTHLY POTENTIAL BENEFITS, AFDC AND FOOD STAMPS, ONE-PARENT FAMILY [1] OF THREE PERSONS, JANUARY 1991—Continued

State	Gross income limit (185 percent of need standard)	100 percent of "need"	Maximum AFDC grant [2]	Food stamp benefit [3]	Combined benefits	Combined benefits as a percent of 1990 poverty threshold [4]	AFDC benefits as a percent of 1990 poverty threshold [4]
New Mexico	574	310	310	274	584	67	36
New York (Suffolk County)	1,301	703	[5] 703	172	875	101	81
New York (New York City)	1,067	577	[5] 577	210	787	91	66
North Carolina	1,006	544	272	277	549	63	31
North Dakota	742	401	401	247	648	75	46
Ohio	1,436	776	[5] 334	271	605	70	38
Oklahoma	871	471	341	265	606	70	39
Oregon	821	444	[5] 444	269	713	82	51
Pennsylvania	1,136	614	421	241	662	76	49
Rhode Island	1,025	554	[5] 554	239	793	91	64
South Carolina	814	440	210	277	487	56	24
South Dakota	712	385	385	252	637	73	44
Tennessee	762	412	195	277	472	54	22
Texas	1,062	574	184	277	461	53	21
Utah	993	537	402	247	649	75	46
Vermont	1,904	1,029	679	163	842	97	78
Virginia	727	393	354	261	615	71	41
Washington	1,819	983	[5] 531	225	756	87	61
West Virginia	919	497	249	277	526	61	29
Wisconsin	1,197	647	517	212	729	84	60
Wyoming	1,247	674	360	259	619	71	41
Guam	611	330	330	409	739	85	38
Puerto Rico	333	180	90	0	90	NA	10
Virgin Islands	555	300	240	356	596	69	28
Median AFDC State [6]	1,500	811	367	262	629	72	42

---

[1] In most States these benefit amounts apply also to 2-parent families of 3 (where the second parent is incapacitated or unemployed). Some, however, increase benefits for such families.

[2] In States with area differentials, figure shown is for area with highest benefit.

[3] Food stamp benefits are based on maximum AFDC benefits shown and assume deductions of $302 monthly ($116 standard household deduction plus $186 maximum allowable deduction for excess shelter cost) in the 48 contiguous States and D.C. In the remaining four jurisdictions these maximum allowable food stamp deductions are assumed: Alaska, $522; Hawaii, $430; Guam, $458; and Virgin Islands, $240. If only the standard deduction were assumed, food stamp benefits would drop by about $55 monthly in most of the 48 contiguous States and D.C. Maximum food stamp benefits from October 1990 through September 1991 are $277 for a family of three

except in these 4 jurisdictions, where they are as follows: Alaska, $361; Hawaii, $452; Guam, $409; and Virgin Islands, $356.

[4] Except for Alaska and Hawaii, this column is based on the Census Bureau's 1990 poverty threshold for a family of three persons, $10,419, converted to a monthly rate of $868. For Alaska, this threshold was increased by 25 percent; for Hawaii, by 15 percent.

[5] In these States part of the AFDC cash payment has been designated as energy aid and is disregarded by the State in calculating food stamp benefits. Illinois disregards $18. Kansas disregards $36. Maryland disregards $59. Michigan disregards $74. New Jersey disregards $25. Ohio disregards $14. New York disregards $53, the full amount of a benefit boost enacted in 1981 ($30) and in 1985 ($23). Oregon disregards $118. Rhode Island disregards $127.85. Washington disregards $56.

[6] With respect to maximum AFDC benefit among 50 States and D.C.

Note.—Puerto Rico does not have a food stamp program, instead a cash nutritional assistance payment is given to recipients.

Source: Table prepared by CRS from information provided by a telephone survey of the States.

TABLE 8.—MAXIMUM AFDC BENEFITS, BY FAMILY SIZE, JANUARY 1991 [1]

State	2-person family	3-person family	4-person family	5-person family	6-person family
Alabama	$93	$124	$155	$186	$217
Alaska* [2]	792	891	990	1,089	1,188
Arizona [3]	233	293	353	412	472
Arkansas	162	204	247	286	331
California*	560	694	824	940	1,057
Colorado [2] [4]	280	356	432	512	590
Connecticut* [5]	549	680	792	893	999
Delaware*	270	338	407	475	544
District of Columbia	336	428	522	602	707
Florida [3]	225	294	346	400	453
Georgia	235	280	330	378	410
Hawaii	504	632	760	888	1,016
Idaho	254	317	357	399	433
Illinois [2] [6]	268	367	414	485	545
Indiana [2]	229	288	346	405	463
Iowa	361	426	495	548	610
Kansas* [7]	338	409	470	525	580
Kentucky	196	228	285	333	376
Louisiana [8]	138	190	234	277	316
Maine [2]	337	453	569	685	801
Maryland	317	406	489	566	623
Massachusetts*	446	539	628	720	814
Michigan:					
(Washtenaw County) [9]	459	555	665	767	909
(Wayne County) [9]	429	525	635	737	879
Minnesota* [2]	437	532	621	697	773
Mississippi	96	120	144	168	192
Missouri	234	292	342	388	431
Montana [2] [3]	295	370	445	519	594
Nebraska*	293	364	435	506	577
Nevada [2]	270	330	390	450	510
New Hampshire*	451	516	575	631	707

TABLE 8.—MAXIMUM AFDC BENEFITS, BY FAMILY SIZE, JANUARY 1991 [1]—Continued

State	2-person family	3-person family	4-person family	5-person family	6-person family
New Jersey*	322	424	488	552	616
New Mexico*	247	310	373	436	499
New York:					
(Suffolk County)* [10]	576	703	824	949	1,038
(New York City)* [10]	468	577	687	800	884
North Carolina	236	272	297	324	349
North Dakota* [2]	326	401	491	558	616
Ohio	274	334	413	483	538
Oklahoma [2]	264	341	423	495	565
Oregon* [2]	380	444	541	634	724
Pennsylvania [11]	330	421	514	607	687
Rhode Island* [12]	449	554	632	710	800
South Carolina	167	210	252	295	337
South Dakota*	340	385	429	473	517
Tennessee	150	195	238	278	322
Texas [2]	158	184	221	246	284
Utah	323	402	470	536	589
Vermont [13]	571	679	762	855	914
Virginia [14]	294	354	410	488	518
Washington	428	531	624	719	817
West Virginia [3]	201	249	312	360	413
Wisconsin [15]	440	517	617	708	766
Wyoming [3]	320	360	390	450	510
Guam*	258	330	417	497	592
Puerto Rico [16]	66	90	114	138	162
Virgin Islands	180	240	300	360	420
Median State [17]	295	367	432	506	577

* These States pay 100 percent of the need standard.

[1] Maximum benefit paid for a family of given size with zero countable income. Family members include 1 adult caretaker.

[2] Alaska, Colorado, Illinois, Indiana, Maine, Minnesota, Montana, North Dakota, Oklahoma, Oregon, and Texas also have a children-only schedule.

[3] Arizona, Florida, Montana, West Virginia and Wyoming have 2 payment schedules, 1 that includes shelter expenses and 1 that does not.

[4] Colorado no longer has separate payment schedules for winter months and nonwinter months.

[5] Connecticut has 3 rent regions. Data shown are from rent region A which has the highest rents.

[6] Illinois divides itself into 3 distinct areas with regard to payment schedules. Data shown are from the Cook County area, which includes Chicago.

[7] Kansas has a basic standard and a shelter standard. The shelter standard varies from area to area (i.e., from $92 monthly to $135 monthly). The shelter payment in Topeka and some of the other larger cities is $109 monthly. The figures shown include a shelter standard of $135 monthly.

[8] Louisiana has 2 payment schedules—1 for urban areas, from which our data were taken, and 1 for rural areas.

[9] Michigan has varied shelter maximums. Shown are benefits for Washtenaw County (Ann Arbor) and Wayne County (Detroit).

[10] New York has payment schedules for each social service district. Shown are the Suffolk County and New York City amounts. The figures include energy payments.

[11] Pennsylvania has four regions. The figures in the table are from region 1, which has the highest benefits.

[12] Rhode Island no longer has separate payment schedules for winter months and nonwinter months.

[13] Vermont has a base amount plus a shelter maximum that depends on whether the recipient is living inside or outside of Chittenden County. The largest amount paid to a recipient with no other income equals 66 percent of the base amount plus 66 percent of the shelter allowance. The shelter maximum for families living in Chittenden County is $373 per month, for those living outside Chittenden County the shelter maximum is $300 monthly.

[14] Virginia has 3 payment schedules. The figures shown are from area 3 which has the highest benefits.

[15] Wisconsin has 2 regions—1 for urban areas, from which our data were taken, and one for rural areas.

[16] Puerto Rico pays 50 percent of need plus 50 percent of rent as paid. The figures assume rent at $20 a month. Officials estimate that $20 is the average amount allowed for rent.

[17] Among 50 States and D.C.

Source: Prepared by Congressional Research Service on the basis of a telephone survey of the States.

Need and payment standards

To receive AFDC payments, a family must pass two income tests: first, a gross income test, and second, a counted ("net") income test. The gross income test is 185 percent of the State's need standard for the relevant family size; and it applies to both applicants and enrollees. This was increased by Congress from 150 percent of the need standard by Public Law 98-369 in 1984. No one with gross income that *exceeds* 185 percent of the need standard can receive AFDC. For applicants, the counted income test is 100 percent of the need standard, and it determines whether the family is deemed to be in "need" (see tables 7 and 8).

However, to be eligible for an actual payment, the family's counted income also must be below the State's payment standard, which in 29 jurisdictions is below the need standard.

Further, a $10 minimum payment rule imposed by Public Law 97-35 requires that counted income be at least $10 below the payment standard for an actual payment to be made.

Table 9 shows the change in the AFDC need standard in selected years, from July 1970 to January 1991, by State. The increase in the median State from July 1970 to July 1975 (a period of 5 years) was 20 percent and from July 1975 to July 1980 it was 15 percent. From July 1980 to January 1991 (a period of 10½ years), the increase was 69 percent. Between July 1970 and January 1991, the Consumer Price Index (CPI) rose an estimated 245 percent, as compared to a 134 percent increase in the AFDC need standard.

Many States increased their need standards (but often not actual benefit levels) after passage of the gross income limit in 1981.

Trends

Table 10 presents information on how the maximum AFDC benefit for a 3-person family with no income has grown from July 1970 to January 1991 by State. In current dollars, the maximum benefit of the median State climbed 28 percent from July 1970–July 1975, 23 percent from July 1975–July 1980, and 27 percent from July 1980–January 1991 (a period of 10½ years).

In constant dollars (after adjustment for inflation), in all but one State (California), benefit levels failed to keep pace with inflation. The median decline in benefit levels adjusted for inflation from 1970 to 1991 was 42 percent.

TABLE 9.—AFDC NEED STANDARD FOR A THREE-PERSON FAMILY BY STATE FOR SELECTED YEARS

	July 1970 [1]	July 1975	July 1980	January 1985 [2]	January 1987 [2]	January 1988 [2]	January 1989 [2]	January 1990 [2]	January 1991 [2]
Alabama	$184	$180	$192	$384	$384	$384	$571	$578	$603
Alaska	350	350	457	719	749	779	809	846	891
Arizona	212	233	233	233	621	621	621	621	621
Arkansas	149	245	234	234	234	695	705	705	705
California	351	316	480	555	617	633	663	694	694
Colorado	193	217	290	421	421	421	421	421	421
Connecticut	283	346	475	546	590	601	623	649	680
Delaware	245	245	266	287	310	319	333	333	338
District of Columbia	229	286	394	654	712	712	712	712	712
Florida	189	195	195	400	400	775	807	838	880
Georgia	177	193	193	366	366	366	376	414	424
Hawaii	226	428	468	468	468	515	557	946	1,012
Idaho	238	345	371	554	554	554	554	554	554
Illinois	232	261	288	657	689	713	740	777	811
Indiana	272	307	307	307	307	320	320	320	320
Iowa	247	309	360	497	497	497	497	497	497
Kansas	243	321	345	373	403	409	427	409	409
Kentucky	208	185	188	197	197	207	218	526	526
Louisiana	172	164	402	538	610	632	658	658	658
Maine	277	277	415	510	558	573	1,169	652	652
Maryland	249	259	270	433	478	497	522	548	562
Massachusetts	268	259	379	439	491	510	539	539	539
Michigan (Washtenaw County)	NA	NA	NA	592	576	576	608	611	622
Michigan (Wayne County)	219	333	425	557	540	540	572	575	586
Minnesota	256	330	417	524	532	532	532	532	532
Mississippi	202	241	220	286	368	368	368	368	368
Missouri	285	325	312	312	312	312	312	312	312
Montana	221	201	259	401	428	434	434	434	453
Nebraska	281	279	310	350	350	350	364	364	364
Nevada	269	279	285	285	285	550	550	550	550
New Hampshire	262	308	346	378	397	486	496	506	516
New Jersey	302	310	360	385	404	424	424	424	424
New Mexico	167	197	220	258	258	264	264	264	310
New York (Suffolk County)	NA	NA	NA	579	602	665	665	703	703
New York (New York City)	279	332	394	474	497	539	539	577	577
North Carolina	168	183	192	446	518	532	532	544	544

TABLE 9.—AFDC NEED STANDARD FOR A THREE-PERSON FAMILY BY STATE FOR SELECTED YEARS—Continued

	July 1970 [1]	July 1975	July 1980	January 1985 [2]	January 1987 [2]	January 1988 [2]	January 1989 [2]	January 1990 [2]	January 1991 [2]
North Dakota	232	283	334	371	371	371	386	386	401
Ohio	207	346	346	627	673	685	712	739	776
Oklahoma	179	217	282	282	471	471	471	471	471
Oregon	229	369	282	386	397	412	420	432	444
Pennsylvania	265	296	332	614	614	614	614	614	614
Rhode Island	229	278	340	479	503	503	517	543	554
South Carolina	162	178	187	187	380	388	403	419	440
South Dakota	264	289	321	329	366	366	366	377	385
Tennessee	179	179	179	246	345	353	365	387	412
Texas	198	155	155	494	574	574	574	574	574
Utah	223	327	480	685	693	693	502	516	537
Vermont	287	402	670	852	859	889	930	973	1,029
Virginia	240	298	344	363	393	393	393	393	393
Washington	258	315	458	768	800	835	872	907	983
West Virginia	220	275	275	275	497	497	497	497	497
Wisconsin	214	383	522	628	641	647	647	647	647
Wyoming	246	240	315	360	360	360	360	360	674
Guam	NA	NA	261	265	265	265	265	330	330
Puerto Rico	108	108	102	180	180	180	180	180	180
Virgin Islands	NA	131	209	209	209	209	300	300	300
Median State [3]	232	279	321	401	471	503	522	539	544

[1] Data on 3-person families were not published or reported before 1975. Thus, the 1970 data were derived by reducing the reported 4-person need standard by the proportional difference between 3- and 4-person AFDC need standards as shown in the July 1975 DHEW reports. [2] CRS survey data. [3] Among 50 States and D.C.

NA—Not available.

Note: Table compiled by the Congressional Research Service (CRS) on the basis of data from the Department of Health and Human Services and, where noted, from CRS itself.

These changes in maximum AFDC benefit levels are summarized in table 10 below. The median State's maximum AFDC benefit (guarantee) for a family of three rose in nominal terms from $184 in fiscal year 1970 to $367 in fiscal year 1991. In constant dollars, however, the median State's guarantee declined 42 percent.

Most AFDC families are eligible also for food stamps (until 1979 all were). As real AFDC benefits declined in the last dozen years, food stamp benefits rose to offset part of their losses. However, combined AFDC-food stamp benefits for a 3-person family without countable income on average dropped from $812 (1990 dollars) in July 1972, when food stamps operated under uniform national rules, to $602 (1990 dollars) in July 1990. This 26 percent drop was almost wholly due to shrinkage in AFDC benefit levels. Food stamp maximum benefits were virtually unchanged in real terms, since they were adjusted for food price inflation in all years except 1982. See Appendix G.

TABLE 10.—AFDC MAXIMUM BENEFIT FOR A THREE-PERSON FAMILY, BY STATE FOR SELECTED YEARS

	July 1970 [1]	July 1975	July 1980	January 1985 [2]	January 1987 [2]	January 1988 [2]	January 1990 [2]	January 1991 [2]	Percent change in 1970–91 [3]
Alabama	$65	$108	$118	$118	$118	$118	$118	$124	−45
Alaska	328	350	457	719	749	779	846	891	−21
Arizona	138	163	202	233	293	293	293	293	−39
Arkansas	89	125	161	164	192	202	204	204	−34
California	186	293	473	555	617	633	694	694	+8
Colorado	193	217	290	346	346	356	356	356	−47
Connecticut	283	346	475	546	590	601	649	680	−30
Delaware	160	221	266	287	310	319	333	338	−39
District of Columbia	195	243	286	327	364	379	409	428	−36
Florida	114	144	195	240	264	275	294	294	−25
Georgia	107	123	164	208	256	263	273	280	−24
Hawaii	226	428	468	468	468	515	602	632	−19
Idaho	211	300	323	304	304	304	317	317	−57
Illinois	232	261	288	341	342	342	367	367	−54
Indiana	120	200	255	256	256	288	288	288	−31
Iowa	201	294	360	360	381	381	410	426	−39
Kansas	222	321	345	373	403	409	409	409	−47
Kentucky	147	185	188	197	197	207	228	228	−55
Louisiana	88	128	152	190	190	190	190	190	−37
Maine	135	176	280	370	405	416	453	453	−3
Maryland	162	200	270	313	345	359	396	406	−27
Massachusetts	268	259	379	396	491	510	539	539	−42
Michigan (Wayne County)	219	333	425	468	473	513	516	525	−31
Minnesota	256	330	417	524	532	532	532	532	−40
Mississippi	56	48	96	96	120	120	120	120	−38
Missouri	104	120	248	263	279	282	289	292	−19
Montana	202	201	259	332	354	359	359	370	−47
Nebraska	171	210	310	350	350	350	364	364	−38
Nevada	121	195	262	233	285	325	330	330	−21
New Hampshire	262	308	346	378	397	486	506	516	−43

TABLE 10.—AFDC MAXIMUM BENEFIT FOR A THREE-PERSON FAMILY, BY STATE FOR SELECTED YEARS—Continued

	July 1970 [1]	July 1975	July 1980	January 1985 [2]	January 1987 [2]	January 1988 [2]	January 1990 [2]	January 1991 [2]	Percent change in 1970–91 [3]
New Jersey...	302	310	360	385	404	424	424	424	−59
New Mexico..	149	169	220	258	258	264	264	310	−40
New York (N.Y. City)	279	332	394	474	497	539	577	577	−40
N.C	145	183	192	223	259	266	272	272	−46
N. Dak..........	213	283	334	371	371	371	386	401	−46
Ohio	161	204	263	290	302	309	334	334	−40
Oklahoma	152	217	282	282	310	310	325	341	−35
Oregon	184	337	282	386	397	412	432	444	−30
Pennsylvania	265	296	332	364	382	402	421	421	−54
Rhode Island.......	229	278	340	479	503	503	543	554	−30
S.C	85	96	129	187	199	200	206	210	−28
S. Dak	264	289	321	329	366	366	377	385	−58
Tennessee.....	112	115	122	138	155	159	184	195	−50
Texas............	148	116	116	167	184	184	184	184	−64
Utah	175	252	360	363	376	376	387	402	−33
Vermont	267	322	492	558	572	603	662	679	−26
Virginia.........	225	268	310	327	354	354	354	354	−54
Washington ..	258	315	458	476	492	492	501	531	−40
West Virginia	114	206	206	206	249	249	249	249	−37
Wisconsin.....	184	342	444	533	544	517	517	517	−19
Wyoming......	213	235	315	360	360	360	360	360	−51
Guam	NA	NA	261	265	265	265	330	330	NA
Puerto Rico ..	43	43	44	90	90	90	90	90	−39
Virgin Islands.....	NA	131	209	171	171	171	240	240	NA
Median State [4]..	184	235	288	332	354	359	364	367	−42

---

[1] Data on 3-person families were not published or reported before 1975. Thus, the 1970 data were derived by reducing the reported 4-person maximum benefit amount by the proportional difference between 3- and 4-person AFDC maximum benefit as shown in the July 1975 DHEW reports.

[2] CRS survey data.

[3] Real percentage change, calculated assuming a January 1991 CPI–U value of 134.6 relative to the July 1970 value of 39.0.

[4] Among 50 States and D.C.

NA—Not available.

Note: Table compiled by CRS on the basis of data from DHHS and, where noted, from CRS itself.

TABLE 11.—HISTORICAL TRENDS IN AVERAGE PAYMENT PER RECIPIENT AND PER FAMILY; AND MAXIMUM AND MEDIAN BENEFITS FOR A FAMILY OF FOUR; FOR SELECTED YEARS FROM 1970 TO 1990 [1]

	1970	1975	1980	1985	1986	1987	1988	1989	1990
AFDC payments:									
Average monthly benefit per family	178	210	274	339	353	359	370	381	377
Average monthly benefit per person	46	63	94	116	120	123	127	131	131
Median State benefit in July for a family unit of 4 with no income [1]	221	264	350	399	415	420	432	432	432
Median State benefit in July in constant 1990 dollars [2]	739	635	552	483	492	481	475	453	432
Maximum State benefit in July for a family unit of 4 with no income	375	497	563	800	823	833	866	899	940
Maximum State benefit in July in constant 1990 dollars [2]	1,254	1,196	888	968	980	955	953	942	940

---

[1] Among 50 States and the District of Columbia.

[2] The constant dollar numbers were calculated using the CPI-U monthly Consumer Price Index series.

Source: Family Support Administration and the Congressional Research Service.

TABLE 12.—INCOME LEVELS AT WHICH AFDC ELIGIBILITY ENDS FOR A FAMILY OF 3, BY STATE AND PERIOD OF RECEIPT, JANUARY 1991 [1] [2]

	185 percent of need standard	Payment standard	AFDC maximum benefit	First 4 months			After 12 months		
				Effective eligibility level	Eligibility level as a percent of—		Effective eligibility level	Eligibility level as a percent of—	
					Poverty level	Minimum wage		Poverty level	Minimum wage
Alabama	$1,116	$124	$124	$306	35	46	$214	25	32
Alaska	1,648	891	891	1,457	168	221	981	113	149
Arizona	1,149	293	293	560	64	85	383	44	58
Arkansas	1,304	204	204	426	49	65	294	34	45

TABLE 12.—INCOME LEVELS AT WHICH AFDC ELIGIBILITY ENDS FOR A FAMILY OF 3, BY STATE AND PERIOD OF RECEIPT, JANUARY 1991 [1] [2]—Continued

				First 4 months			After 12 months		
	185 percent of need standard	Payment standard	AFDC maximum benefit	Effective eligibility level	Eligibility level as a percent of—		Effective eligibility level	Eligibility level as a percent of—	
					Poverty level	Minimum wage		Poverty level	Minimum wage
California	1,284	694	694	1,161	134	176	784	90	119
Colorado	779	421	356	752	87	114	511	59	78
Connecticut	1,258	680	680	1,140	131	173	770	89	117
Delaware	625	338	338	627	72	95	428	49	65
District of Columbia	1,317	428	428	762	88	116	518	60	79
Florida	1,628	294	294	561	65	85	384	44	58
Georgia	784	424	280	756	87	115	514	59	78
Hawaii	1,872	632	632	1,068	123	162	722	83	110
Idaho	1,025	317	317	596	69	90	407	47	62
Illinois	1,500	367	367	671	77	102	457	53	69
Indiana	592	288	288	552	64	84	378	44	57
Iowa	919	426	426	759	87	115	516	59	78
Kansas	757	409	409	734	85	111	499	57	76
Kentucky	973	526	228	909	105	138	616	71	93
Louisiana	1,217	190	190	405	47	61	280	32	42
Maine	1,206	652	453	1,098	126	167	742	85	113
Maryland	1,040	406	406	729	84	111	496	57	75
Massachusetts	997	539	539	929	107	141	629	72	95
Michigan (Wayne County)	1,084	525	525	908	105	138	615	71	93
Minnesota	984	532	532	918	106	139	622	72	94
Mississippi	681	368	120	672	77	102	458	53	69
Missouri	577	292	292	558	64	85	382	44	58
Montana	838	370	370	675	78	102	460	53	70
Nebraska	673	364	364	666	77	101	454	52	69
Nevada	1,018	330	330	615	71	93	420	48	64
New Hampshire	955	516	516	894	103	136	606	70	92
New Jersey	784	424	424	756	87	115	514	59	78
New Mexico	574	310	310	585	67	89	400	46	61
New York (New York City)	1,067	577	577	986	114	150	667	77	101
North Carolina	1,006	272	272	528	61	80	362	42	55
North Dakota	742	401	401	722	83	109	491	57	75
Ohio	1,436	334	334	621	72	94	424	49	64
Oklahoma	871	341	341	632	73	96	431	50	65
Oregon	821	444	444	786	91	119	534	62	81
Pennsylvania	1,136	421	421	752	87	114	511	59	78
Rhode Island	1,025	554	554	951	110	144	644	74	98
South Carolina	814	440	210	780	90	118	530	61	80
South Dakota	712	385	385	698	80	106	475	55	72

TABLE 12.—INCOME LEVELS AT WHICH AFDC ELIGIBILITY ENDS FOR A FAMILY OF 3, BY STATE AND PERIOD OF RECEIPT, JANUARY 1991 [1] [2]—Continued

	185 percent of need standard	Payment standard	AFDC maximum benefit	First 4 months			After 12 months		
				Effective eligibility level	Eligibility level as a percent of—		Effective eligibility level	Eligibility level as a percent of—	
					Poverty level	Minimum wage		Poverty level	Minimum wage
Tennessee	762	412	195	738	85	112	502	58	76
Texas	1,062	184	184	396	46	60	274	32	42
Utah	993	537	402	926	107	140	627	72	95
Vermont	1,904	679	679	1,139	131	173	769	89	117
Virginia	727	354	354	651	75	99	444	51	67
Washington	1,819	531	531	917	106	139	621	72	94
West Virginia	919	249	249	494	57	75	339	39	51
Wisconsin	1,197	517	517	896	103	136	607	70	92
Wyoming	1,247	360	360	660	76	100	450	52	68
Guam	611	330	330	615	71	93	420	48	64
Puerto Rico	333	90	90	255	29	39	180	21	27
Virgin Islands	555	240	240	480	55	73	330	38	50

[1] These calculations assume no child care expenses and work expenses of $90 per month. The breakevens for 5–12 months can be obtained by adding $30 to the breakeven for "After 12 months." The calculations are also based on a 1990 poverty level of $10,419 ($868 per month) for a family of three, and a 1991 minimum wage salary of $7,904 ($659 per month).

[2] Income level at which Medicaid eligibility ends. Because of minimum payment rule, actual AFDC benefits may end at a slightly different income level.

Source: Congressional Research Service.

FEDERAL AND STATE FUNDING OF AFDC BENEFIT PAYMENTS, JOBS AND SUPPORTIVE SERVICES

AFDC benefit payments and administrative costs

The Federal share of a State's AFDC benefit payments is determined by the matching formula specified for Medicaid in title XIX of the Social Security Act (States may choose an alternate formula, but none do so). The Federal Medicaid matching rate is inversely related to State per capita income; thus, Federal matching for AFDC benefit payments varies from State to State, ranging from 50 percent in States with high per capita incomes to close to 80 percent in Mississippi, a State with relatively low per capita income. Table 13 provides State-specific information on the Federal share of AFDC benefit payments.

For the outlying areas—Guam, Puerto Rico and the Virgin Islands—75 percent Federal matching is provided for AFDC benefits, but the law imposes a ceiling on total Federal funds for AFDC and several other programs. The ceilings are as follows: Puerto Rico, $82 million; Guam, $3.8 million; and the Virgin Islands, $2.8 million.

The Federal Government pays 50 percent of the costs of administering the AFDC program in all States.

Some States require their localities to finance a portion of the non-Federal share of benefit payments (see table 14), and the non-Federal share of administrative costs (see table 15).

Table 16 provides information on total Federal and State benefit payments under the single parent and unemployed parent programs for fiscal years 1970 through 1990, and DHHS projections for fiscal years 1991 through 1996 (for State-level data on benefit payments, see table 19). Table 17 breaks these data down into their Federal and State shares, and also includes information on administrative costs for the AFDC program.

JOBS and supportive services

Federal matching for JOBS program costs is available as a capped entitlement limited to $600 million in fiscal year 1989, $800 million in fiscal year 1990, $1 billion in fiscal year 1991, 1992 and 1993, $1.1 billion in fiscal year 1994, $1.3 billion in fiscal year 1995, and $1.0 billion a year thereafter. The Federal match is 90 percent for expenditures up to the amount alloted to the States for the WIN program in fiscal year 1987. Of additional amounts, the Federal match is at the Medicaid rate, with a minimum Federal match of 60 percent, for nonadministrative costs and for personnel costs for full-time staff working on the JOBS program. The match for other administrative costs is 50 percent. The Federal match for JOBS is reduced to 50 percent unless 55 percent of funds are spent on certain target populations. The entitlement cap for JOBS is allocated as follows: States receive an amount equal to their WIN allotment for fiscal year 1987 ($126 million for all States) and the remainder is allocated on the basis of each State's relative number of adult recipients of AFDC. Federal program funds may not be used to supplant non-Federal funds for existing services and activities.

Child care during participation in JOBS and for employment is reimbursed as a separate, open-ended entitlement at the Medicaid matching rate. Transportation and other work-related expenses are reimbursed at a rate of 50 percent and are included among those expenditures subject to the JOBS entitlement cap.

Table 18 provides information on State allocations for the JOBS program for fiscal year 1990, along with information on the amount of these funds States have expended and obligated. The table also includes information on State expenditures for child care.

TABLE 13.—FEDERAL SHARE OF AFDC BENEFITS PAYMENTS,[1] SELECTED FISCAL YEARS 1984 THROUGH 1992

[In percent]

State	1984–85 [2]	1986	1988	1990	1991	1992
Alabama	72.14	72.30	73.29	73.21	72.73	72.93
Alaska	50.00	50.00	50.00	50.00	50.00	50.00
Arizona	61.21	62.28	62.12	60.99	61.72	62.61
Arkansas	73.65	73.83	74.21	74.58	75.12	75.66
California	50.00	50.00	50.00	50.00	50.00	50.00

TABLE 13.—FEDERAL SHARE OF AFDC BENEFITS PAYMENTS,[1] SELECTED FISCAL YEARS 1984 THROUGH 1992—Continued

[In percent]

State	1984–85 [2]	1986	1988	1990	1991	1992
Colorado	50.00	50.00	50.00	52.11	53.59	54.79
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	51.90	50.00	50.00	50.12
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00
Florida	58.41	56.16	55.39	54.70	54.46	54.69
Georgia	67.43	66.05	63.84	62.09	61.34	61.78
Guam (Federal funds limited) [3]	75.00	75.00	75.00	75.00	75.00	75.00
Hawaii	50.00	51.00	53.71	54.50	54.14	52.57
Idaho	67.28	69.36	70.47	73.32	73.65	73.24
Illinois	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	59.93	62.82	63.71	63.76	63.24	63.85
Iowa	55.24	58.90	62.75	62.52	63.41	65.04
Kansas	50.67	50.00	55.20	56.07	57.35	59.23
Kentucky	70.72	70.23	72.27	72.95	72.96	72.82
Louisiana	64.65	63.81	68.26	73.12	74.48	75.44
Maine	70.63	68.86	67.08	65.20	63.49	62.40
Maryland	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	50.13	50.00	50.00	50.00	50.00	50.00
Michigan	50.70	56.79	56.48	54.54	54.17	55.41
Minnesota	52.67	53.41	53.98	52.74	53.43	54.43
Mississippi	77.63	78.42	79.65	80.18	79.93	79.99
Missouri	61.40	60.62	59.27	59.18	59.82	60.84
Montana	64.41	66.38	69.40	71.35	71.73	71.70
Nebraska	57.13	57.11	59.73	61.12	62.71	64.50
Nevada	50.00	50.00	50.25	50.00	50.00	50.00
New Hampshire	59.45	54.92	50.00	50.00	50.00	50.00
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	69.39	68.94	71.52	72.25	73.38	74.33
New York	50.88	50.00	50.00	50.00	50.00	50.00
North Carolina	69.54	69.18	68.68	67.46	66.60	66.52
North Dakota	61.32	55.12	64.87	67.52	70.00	72.75
Ohio	55.44	58.30	59.10	59.57	59.93	60.63
Oklahoma	58.47	57.60	63.33	68.29	69.65	70.74
Oregon	57.12	61.54	62.11	62.95	63.50	63.55
Pennsylvania	56.04	56.72	57.35	56.86	56.64	56.84
Puerto Rico (Federal funds limited) [3]	75.00	75.00	75.00	75.00	75.00	75.00
Rhode Island	58.17	56.33	54.85	55.15	53.74	53.29

TABLE 13.—FEDERAL SHARE OF AFDC BENEFITS PAYMENTS,[1] SELECTED FISCAL YEARS 1984 THROUGH 1992—Continued

[In percent]

State	1984–85 [2]	1986	1988	1990	1991	1992
South Carolina	73.51	72.70	73.49	73.07	72.58	72.66
South Dakota	68.31	67.82	70.43	70.90	71.69	72.59
Tennessee	70.66	70.20	70.64	69.64	68.57	68.41
Texas	54.37	53.56	56.91	61.23	63.53	64.18
Utah	70.84	72.62	73.73	74.70	74.89	75.11
Vermont	69.37	67.06	66.23	62.77	61.97	61.37
Virgin Islands (Federal funds limited) [3]	75.00	75.00	75.00	75.00	75.00	75.00
Virginia	56.53	53.14	51.34	50.00	50.00	50.00
Washington	50.00	50.06	53.21	53.88	54.21	54.98
West Virginia	70.57	71.53	74.84	76.61	77.00	77.68
Wisconsin	56.87	57.54	58.98	59.28	59.62	60.38
Wyoming	50.00	50.00	57.96	65.95	68.14	69.10

---

[1] The Federal share of the AFDC program is calculated by the same formula used to determine the Federal share of medicaid costs except in States that elect an alternate formula or have no medicaid program. Texas chose the alternate formula until July 1, 1983. Arizona used the alternate formula until the first quarter of fiscal year 1983, when it was deemed qualified to use the medicaid formula for the first time. For Texas it was 55.75 for fiscal years 1982 and 1983.

[2] Effective Oct. 1, 1983, through Sept. 30, 1985.

[3] Public Law 96–272 made permanent the 75-percent matching rate for AFDC effective Oct. 1, 1979. For medicaid the matching rate remains 50 percent.

Source: Department of Health and Human Services, Family Support Administration.

TABLE 14.—FINANCING OF NON-FEDERAL SHARE OF BENEFIT PAYMENTS, FOR STATES USING STATE AND LOCAL FUNDS, AS OF OCTOBER 1990

	Percent State funds	Percent local funds
California	89.2	10.8
Colorado	57.3	42.7
Indiana	60.0	40.0
Minnesota [1]	85.0	15.0
Montana [2]	77.5	22.5
New Jersey	75.0	25.0
New York [3]	50.0	50.0
North Carolina [4]	50.0	50.0
North Dakota [4]	75.0	25.0
Ohio [5]	36.37	5.0
Wisconsin [6]	100.0	....

---

[1] Counties finance 90 percent of the non-Federal costs emergency assistance program.

[2] For all cases in State-administered counties and Indian cases in State-supervised counties, State funds only.

[3] For persons with State residence. For persons without State residence, for persons eligible for public assistance and care under AFDC and who are released from a State mental hygiene facility after a stay of 5 or more years, and for Indians living on reservations, State pays 100 percent of assistance.

[4] State pays 100 percent for Indians living on reservations.

[5] Percentage of total costs before deduction of Federal share.

[6] State pays State costs and up to 100 percent of local costs. Localities pay foster care and institutional costs in excess of State appropriations.

Source: "Characteristics of State Plans for AFDC," Family Support Administration.

TABLE 15.—FINANCING OF NON-FEDERAL SHARE OF COSTS OF ADMINISTRATION, FOR STATES USING STATE AND LOCAL FUNDS, AS OF OCTOBER 1990

	Percent state funds	Percent local funds
Arkansas	100% in 50 counties; lesser proportion in 25 counties.	25 counties participate in maintenance costs.
California	100% of State costs; 50% of local costs.	50% of local costs.
Colorado	60%	40%
Indiana	100% of State costs, plus up to 50% of specified local costs.	50% or more of specified local costs.
Iowa	100% of State and district costs.	100% of local costs.
Maryland	100% of State budgeted positions.	100% of local and nonbudgeted positions.
Minnesota	Varies with appropriations	Varies with State appropriations.
Mississippi	Varies according to county population.	Varies according to county population.
Montana [1]	66.7%	33.3%.
Nebraska	Varies	Local funds used for some travel, rent, and equipment.
New Jersey	100% of State costs	100% of local costs.
New York	50% (or 100% for Indians living on reservations).	50%.
North Carolina	100% of State costs and varying proportion of local costs, based on prior actual expenditures.	Portion of local costs not covered by State appropriation.
North Dakota	100% of State costs	100% of local costs if able.
Ohio	36.73% [2]	5%.
South Dakota	100% of State costs	100% of local costs.
Virginia	60%	40%.
Wisconsin	100% of State costs and up to 100% of local costs.	Any costs in excess of State appropriation.

[1] State pays all administrative costs in State-administered counties.

[2] Percentage of total cost before deduction of Federal share (58.27%).

Source: "Characteristics of State Plans for AFDC," Family Support Administration.

TABLE 16.—FEDERAL AND STATE AFDC BENEFIT PAYMENTS UNDER THE SINGLE PARENT AND UNEMPLOYED PARENT PROGRAMS: FISCAL YEARS 1970 TO 1996

[In millions of dollars]

Fiscal year	Single parent [1] (1)	Unemployed parent (2)	Total, columns (1) and (2) [2] (3)	Child support collections [3] (4)	Total, columns (3) minus (4) [4] (5)	Column (5) expressed in 1990 constant dollars [5] (6)
1970	3,851	231	4,082	0	4,082	13,909
1971	4,993	412	5,405	0	5,405	17,536
1972	5,972	422	6,394	0	6,394	19,989
1973	6,459	414	6,873	0	6,873	20,683
1974	6,881	324	7,205	0	7,205	19,914
1975	7,791	362	8,153	0	8,153	20,272
1976	8,825	525	9,350	286	9,064	21,035
1977	9,420	617	10,037	423	9,614	20,742
1978	9,624	565	10,189	472	9,717	19,586
1979	9,865	522	10,387	597	9,790	17,911
1980	10,847	693	11,540	603	10,937	17,609
1981	11,769	1,075	12,844	671	12,173	17,636
1982	11,601	1,256	12,857	786	12,071	16,297
1983	12,136	1,471	13,607	880	12,727	16,591
1984	12,759	1,612	14,371	1,000	13,371	16,736
1985	13,401	1,556	14,957	903	14,054	16,981
1986	14,234	1,563	15,797	960	14,837	17,484
1987	14,792	1,516	16,308	1,078	15,230	17,452
1988	15,243	1,420	16,663	1,207	15,456	17,000
1989	15,889	1,350	17,239	1,288	15,951	16,744
1990	17,055	1,480	18,535	1,420	17,115	17,115
1991 [6]	18,913	1,798	20,711	1,588	19,123	18,151
1992 [6]	19,969	2,115	22,084	1,780	20,304	18,600
1993 [6]	20,715	2,152	22,867	2,003	20,864	18,444
1994 [6]	21,344	2,126	23,470	2,238	21,232	18,122
1995 [6]	21,968	2,092	24,060	2,510	21,550	17,747
1996 [6]	22,562	2,067	24,629	2,796	21,833	17,359

---

[1] Includes payments to two-parent families where one adult is incapacitated.

[2] Total AFDC benefits of which a portion are reimbursed by child support collections. Total may not add due to rounding. Unlike table 17, this table does not include foster care payments under the AFDC program from 1971 to 1980.

[3] Total AFDC collections less payments to recipients.

[4] Net AFDC benefits—Gross benefits less those reimbursed by child support collections.

[5] Net AFDC benefits in constant 1990 dollars. Adjusted based on the CPI-U index. Projections of the CPI-U index for fiscal years 1990-1996 from the Administration.

[6] Administration projections under current law.

Source: Office of Financial Management, Family Support Administration.

TABLE 17.—TOTAL, FEDERAL, AND STATE AFDC EXPENDITURES: FISCAL YEARS 1970 TO 1996

[In millions of dollars]

Fiscal year	Federal share		State share		Total	
	Benefits	Administrative	Benefits	Administrative	Benefits	Administrative
1970	2,187	[1] 572	1,443	186	4,082	[1] 881
1971	3,008	271	2,469	254	5,477	525
1972	3,612	[2] 240	2,942	241	6,554	NA
1973	3,865	313	3,138	296	7,003	610
1974	4,071	379	3,300	362	7,371	740
1975	4,625	552	3,787	529	8,412	1,082
1976	5,258	541	4,418	527	9,676	1,069
1977	5,626	595	4,762	583	10,388	1,177
1978	5,701	631	4,890	617	10,591	1,248
1979	5,825	683	4,954	668	10,779	1,350
1980	6,448	750	5,508	729	11,956	1,479
1981	6,928	835	5,917	814	12,845	1,648
1982	6,922	878	5,934	878	12,857	1,756
1983	7,332	915	6,275	915	13,607	1,830
1984	7,707	876	6,664	822	14,371	1,698
1985	8,019	890	6,938	889	14,957	1,779
1986	8,543	993	7,254	967	15,797	1,960
1987	8,906	1,081	7,402	1,051	16,308	2,133
1988	9,125	1,194	7,538	1,159	16,663	2,353
1989	9,436	1,211	7,809	1,206	17,245	2,417
1990	10,147	1,358	8,388	1,303	18,535	2,661
1991 [3]	11,378	1,448	9,333	1,389	20,711	2,837
1992 [3]	12,205	1,513	9,879	1,453	22,084	2,966
1993 [3]	12,639	1,581	10,228	1,517	22,867	3,098
1994 [3]	12,972	1,633	10,498	1,573	23,470	3,206
1995 [3]	13,297	1,685	10,763	1,631	24,060	3,316
1996 [3]	13,611	1,726	11,018	1,679	24,629	3,405

[1] Includes expenditures for services.

[2] Administrative expenditures only.

[3] Administration projection under current law.

NA=Not available.

Note.—Benefits do not include emergency assistance payments or reimbursement from child support enforcement collections. Foster care payments are included from 1971 to 1980. Beginning in fiscal year 1984, the cost of certifying AFDC households for food stamps are shown in the food stamp appropriation, U.S. Department of Agriculture. Administrative figures include training expenditures.

Source: Office of Financial Management, Family Support Administration.

TABLE 18. ALLOCATIONS AND EXPENDITURES FOR THE JOBS PROGRAM, FISCAL YEAR 1990

[In millions of dollars]

	Jobs—total authorization [1]	Indian set-aside [2]	Less sequester amount [3]	Limit of entitlement [4]	Total		Title IV—A child care
					Expended [5]	Obligated [6]	
Alabama	8.2		(7)	4.1	.8	1.1	.3
Alaska	1.7	.6		.6	.6	.6	(7)
Arizona	6.9	.4		.4	(7)	.1	.1
Arkansas	4.5		(7)	4.5	4.0	4.2	2.2
California	126.2	.1	.8	125.3	63.1	117.8	14.2
Colorado	8.3	(7)	.1	6.1	2.1	2.1	1.1
Connecticut	8.4		.1	8.3	8.3	8.3	3.2
Delaware	1.6		(7)	1.6	1.0	1.1	.9
District of Columbia	3.0		(7)	1.5	1.5	1.5	.7
Florida	19.2		.1	19.2	12.4	12.4	10.5
Georgia	17.0		.1	16.9	6.0	6.2	6.9
Guam	.3			0	0		0
Hawaii	3.5			0	0		(7)
Idaho	2.1	(7)		.03	(7)	(7)	(7)
Illinois	44.0		.1	21.9	7.1	14.7	1.9
Indiana	10.5			0	0		(7)
Iowa	7.9		.1	7.8	5.0	5.0	1.7
Kansas	5.4	(7)	(7)	5.3	4.0	4.0	2.0
Kentucky	10.9			0	0		(7)
Louisiana	16.4			0	0		.1
Maine	4.3			0	0		.1
Maryland	13.5		.1	13.4	10.3	12.3	7.9
Massachusetts	20.7		.2	20.5	13.8	17.8	14.1
Michigan	51.7	.1	.4	51.3	23.1	23.1	5.2
Minnesota	13.5	.6	.1	12.8	8.7	8.7	7.4
Mississippi	10.5			0	0		(7)
Missouri	14.8		(7)	3.7	.7	.7	.1
Montana	2.5	.1	(7)	.6	.5	.5	0
Nebraska	2.9		(7)	2.9	1.5	1.5	2.4
Nevada	1.5		(7)	1.5	.5	.5	.5
New Hampshire	1.1		(7)	1.1	.7	.8	.7
New Jersey	22.4		.2	22.2	22.2	22.2	6.8
New Mexico	4.0	.2	(7)	2.8	.6	.8	.7
New York	73.5	.1		.1	.1	.1	2.5
North Carolina	13.9	(7)		(7)	(7)	(7)	.1
North Dakota	1.4	.3	(7)	.5	.5	.8	.4
Ohio	48.2		.3	47.9	17.3	43.7	3.3
Oklahoma	6.9	(7)	(7)	6.8	5.0	5.0	1.0
Oregon	9.0			0	0		.4
Pennsylvania	38.6		.3	38.4	16.8	27.5	0
Puerto Rico	11.9			0	0		0
Rhode Island	3.5		(7)	3.5	2.8	3.3	1.8
South Carolina	6.7		(7)	6.6	3.1	5.0	.1
South Dakota	1.6	.4	(7)	1.2	1.0	1.4	.6
Tennessee	13.0			0	0		.1

TABLE 18. ALLOCATIONS AND EXPENDITURES FOR THE JOBS PROGRAM, FISCAL YEAR 1990—Continued

[In millions of dollars]

	Jobs—total authorization [1]	Indian set-aside [2]	Less sequester amount [3]	Limit of entitlement [4]	Total		Title IV—A child care
					Expended [5]	Obligated [6]	
Texas	33.1			0	0		1.7
Utah	4.0	(7)	(7)	3.9	3.6	3.6	4.8
Vermont	2.3			0	0		1.3
Virgin Islands	.3		(7)	.1	(7)	13.6	0
Virginia	10.7			0	0		(7)
Washington	19.8	.2		.2	.2	.2	4.6
West Virginia	9.7		.1	9.7	3.2	3.2	.9
Wisconsin	21.0	(7)	.2	20.7	19.7	20.7	5.4
Wyoming	1.2	.1	(7)	.3	(7)	.3	.1
Total (8)	799.9	3.4	3.6	496.0	271.9	382.8	120.8

[1] JOBS—total authorization: Total federal funds available for the JOBS program for fiscal year 1990.

[2] Indian set-aside: Ratio of adult recipients in a tribal service area to the State's total of adult recipients multiplied by the State's total allocation.

[3] Less sequester amount: Automatic reductions of Federal funds based on the provisions of the Balanced Budget and Emergency Deficit Control Act of 1985.

[4] Limit of entitlement: The limit of entitlement equals the total authorization minus the Indian set-aside minus the sequester amount. If the State JOBS plan was approved for only 6 months (e.g., Alabama's plan), the entitlement was based on 50 percent of the total authorization.

[5] Total expended: The amount of funds that left the State's treasury through September 30, 1990, for the program.

[6] Total obligated: The amount of funds obligated by the State by September 30, 1990. For example, if a contract is signed by the State to provide services based on a set fee, the amount owed for those services is an obligation. That obligation becomes an expenditure only when the invoice for the services is actually paid.

[7] Denotes allocations and expenditures of less than $50,000

[8] American Samoa allocation of $69,063 is not included in the total.

Note: Data are up to date as of February 1, 1991, except for child care data which are as of January 1991.

Source: Family Support Administration.

AFDC CASELOAD DATA

Table 19 presents State-specific information on caseloads and benefit payments under the AFDC single parent and unemployed parent programs. Average monthly benefits per AFDC family were $377 in fiscal year 1990. Table 20 provides similar information for the unemployed parents program only.

Table 21 presents data on the average monthly number of families and individuals receiving AFDC benefits since 1970. The table includes information on families and individuals in both the single parent and unemployed parent programs. In fiscal year 1990, the average monthly family enrollment in the combined programs was 4.0 million, and 203 thousand of these families were in the unemployed parent program. The table also includes historical information on the average monthly benefit under the combined programs.

The number of AFDC families rose more than 50 percent from 1971 to 1981, reaching a high of 3.9 million (monthly average) in 1981. In 1982, after OBRA took effect, the number dropped 8 percent, but in 1983 it rose 2.3 percent. Enrollment in 1990 is just above that of 1981.

Table 22 shows the number of total AFDC recipients and the number of child recipients for 1970 to 1989, and shows these numbers as percentages of the total population and the poverty population, respectively. As a percentage of the total population, AFDC recipients have fallen about half a percentage point from the mid-1970s to 1989. The percentage of children receiving AFDC has remained relatively constant at around 11 percent since 1972, hitting a low of 10.75 percent in 1982. As a percentage of children in poverty, child AFDC recipients have fallen from a high of 80.5 percent in 1973 to a low of 49.6 percent in 1982, and have risen to 57.9 percent in 1989.

TABLE 19.—AVERAGE MONTHLY NUMBER OF AFDC FAMILIES AND RECIPIENTS, TOTAL BENEFIT PAYMENTS AND ADMINISTRATIVE COSTS, AND AVERAGE PAYMENT PER FAMILY AND PERSON, FISCAL YEAR 1990 (PRELIMINARY DATA)

State	Total assistance payments (millions)	Average monthly caseload	Average monthly recipients	Average payment per		Total administrative costs (in millions) [1]	Annual administrative cost per AFDC family
				Family	Person		
Alabama	$61.5	45,224	129,740	$114	$40	$15.9	$339
Alaska	59.5	7,615	20,107	651	246	8.7	1139
Arizona	138.4	43,119	124,027	269	94	15.3	365
Arkansas	56.9	24,679	70,903	191	66	10.6	428
California	4,954.9	651,703	1,901,355	637	218	430.3	654
Colorado	136.8	35,619	102,033	319	111	19.8	550
Connecticut	295.2	43,356	119,768	570	206	34.4	755
Delaware	28.7	8,273	21,160	291	114	8.4	1017
District of Columbia	84.0	18,263	48,260	384	145	28.4	1486
Florida	417.5	134,337	368,548	263	96	84.6	613
Georgia	320.7	101,708	292,951	263	91	57.0	569
Hawaii	98.8	14,336	43,917	575	188	7.6	497
Idaho	19.5	6,063	16,427	268	99	7.6	1244
Illinois	838.7	208,286	635,514	343	112	100.3	452
Indiana	170.0	53,685	152,959	265	93	29.9	560
Iowa	152.4	34,396	97,209	369	131	13.2	385
Kansas	105.1	25,800	77,045	340	114	18.6	663
Kentucky	179.1	66,299	175,185	225	85	26.8	403
Louisiana	188.0	93,510	280,847	168	56	23.6	252
Maine	101.4	19,746	55,597	426	151	13.0	538
Maryland	295.8	66,918	185,642	368	133	40.2	576
Massachusetts	630.3	93,655	258,999	565	204	72.2	747
Michigan	1,211.3	217,949	654,552	465	155	143.1	656
Minnesota	354.9	56,590	169,832	518	173	43.9	761
Mississippi	86.3	59,597	177,387	121	40	9.9	165
Missouri	227.9	70,899	210,772	273	92	27.2	384
Montana	40.4	9,652	28,641	345	116	5.5	551
Nebraska	58.6	14,602	42,561	336	115	9.2	624

TABLE 19.—AVERAGE MONTHLY NUMBER OF AFDC FAMILIES AND RECIPIENTS, TOTAL BENEFIT PAYMENTS AND ADMINISTRATIVE COSTS, AND AVERAGE PAYMENT PER FAMILY AND PERSON, FISCAL YEAR 1990 (PRELIMINARY DATA)—Continued

State	Total assistance payments (millions)	Average monthly caseload	Average monthly recipients	Average payment per		Total administrative costs (in millions) [1]	Annual administrative cost per AFDC family
				Family	Person		
Nevada	27.2	8,141	22,573	278	100	6.9	825
New Hampshire	31.8	6,261	16,329	428	164	4.1	598
New Jersey	450.8	106,914	308,953	263	91	122.9	785
New Mexico	60.5	21,315	61,445	236	82	10.7	499
New York	2,249.9	344,608	981,066	416	146	536.3	987
North Carolina	246.7	86,400	223,035	238	92	50.1	579
North Dakota	24.3	5,545	15,471	366	131	3.6	643
Ohio	879.2	224,219	625,330	325	117	95.5	288
Oklahoma	132.1	39,115	112,729	277	96	34.4	877
Oregon	145.2	32,739	89,016	370	136	41.5	1261
Pennsylvania	798.3	177,591	520,435	374	128	131.2	724
Rhode Island	99.0	16,632	46,117	498	179	8.2	492
South Carolina	95.7	38,631	110,146	206	72	24.4	621
South Dakota	21.7	6,691	18,972	271	96	3.6	540
Tennessee	167.9	76,125	210,297	183	66	28.2	371
Texas	415.9	208,475	610,123	167	57	70.4	336
Utah	64.1	15,490	45,011	345	119	10.8	694
Vermont	48.1	7,736	21,912	520	184	5.6	715
Virginia	177.4	56,120	150,778	263	98	38.1	679
Washington	437.9	81,312	228,190	450	160	69.3	853
West Virginia	110.0	36,169	108,676	255	85	6.5	176
Wisconsin	440.4	79,360	237,430	464	155	35.1	292
Wyoming	19.3	5,281	14,135	305	114	3.4	640
Guam	5.0	1,172	4,105	359	102	0.7	569
Puerto Rico	71.5	58,514	189,627	104	32	13.3	235
Virgin Islands	2.9	884	3,203	279	77	0.5	572
U.S. total	18,535.4	3,967,319	11,437,042	377	131	2,660.5	593

---

[1] Administrative costs includes Other State and Local, Work Program, ADP, FAMIS, Fraud and SAVE expenditures.

Source: Family Support Administration (financial data: FSA-231, caseload data: FSA-3637).

TABLE 20.—AFDC–UP RECIPIENTS OF CASH PAYMENTS AND AMOUNTS OF PAYMENTS BY STATE, FISCAL YEAR 1990 (INCLUDES NONMEDICAL VENDOR PAYMENTS, PRELIMINARY DATA)

State	UP money payments (thousands)	Average number of families	Average number of recipients	Average payment per—	
				Family	Recipient
California	$762,363	79,243	365,033	$802	$174
Connecticut	5,496	664	2,896	690	159
Delaware	186	51	194	304	80
District of Columbia	423	79	361	446	98
Guam	236	36	194	545	101
Hawaii	4,050	482	2,373	700	142
Illinois	45,728	9,231	40,670	413	94
Iowa	10,588	2,045	8,787	431	100
Kansas	9,113	1,882	8,111	404	94
Maine	9,391	1,333	5,830	587	134
Maryland	3,403	587	2,576	483	110
Massachusetts	13,974	1,660	7,514	701	155
Michigan	164,756	24,433	103,545	562	133
Minnesota	50,497	6,968	32,413	604	130
Missouri	14,555	3,628	15,871	334	76
Montana	846	945	4,221	75	17
Nebraska	4,790	965	4,203	414	95
New Jersey	12,409	2,340	10,792	442	96
New York	65,194	9,399	40,268	578	135
North Carolina	839	212	885	330	79
Ohio	110,952	22,383	90,655	413	102
Oregon	5,790	1,140	4,886	423	99
Pennsylvania	33,749	7,189	30,826	391	91
Rhode Island	1,273	181	807	586	131
South Carolina	1,012	315	1,453	268	58
Vermont	4,306	676	2,806	531	128
Washington	56,228	8,453	36,659	554	128
West Virginia	29,410	7,913	34,024	310	75
Wisconsin	58,179	8,406	39,890	577	122
Wyoming	238	(1)	(1)		
U.S. total	$1,479,975	202,839	898,733	$608	$137

[1] Not reported.

Source: Family Support Administration (Financial data: FSA–231; caseload: FSA–3637).

TABLE 21.—HISTORICAL TRENDS IN AFDC ENROLLMENTS AND AVERAGE PAYMENTS

Fiscal year	Average monthly number of (in thousands)					Average monthly benefit	
	Families [1]	Recipients [1]	Children [1]	Unemployed parent families	Unemployed parent recipients	Family	Recipient
1970	1,909	7,429	5,494	78	420	$178	$46
1971	2,532	9,556	6,963	143	726	180	48
1972	2,918	10,632	7,698	134	639	187	51
1973	3,123	11,038	7,965	120	557	187	53
1974	3,170	10,845	7,824	95	434	194	57
1975	3,342	11,067	7,928	101	451	210	63
1976	3,561	11,339	8,156	135	593	226	71
1977	3,575	11,108	7,818	149	659	242	78
1978	3,528	10,663	7,475	127	567	250	83
1979	3,493	10,311	7,193	113	504	257	87
1980	3,642	10,597	7,320	141	612	274	94
1981	3,871	11,160	7,615	209	881	277	96
1982	3,569	10,431	6,975	232	976	300	103
1983	3,651	10,659	7,051	272	1,144	311	106
1984	3,725	10,866	7,153	287	1,222	322	110
1985	3,692	10,813	7,165	261	1,131	339	116
1986	3,747	10,995	7,294	253	1,101	352	120
1987	3,784	11,065	7,381	236	1,035	359	123
1988	3,748	10,920	7,326	210	929	370	127
1989	3,771	10,935	7,370	193	856	381	131
1990	3,967	11,439	7,744	203	899	389	135
1991 [2]	4,308	12,415	8,404	265	1,094	401	139
1992 [2]	4,455	12,843	8,694	317	1,263	413	143
1993 [2]	4,510	12,973	8,782	318	1,251	423	147
1994 [2]	4,536	13,021	8,815	308	1,203	431	150
1995 [2]	4,559	13,064	8,844	297	1,150	440	153
1996 [2]	4,579	13,106	8,873	289	1,116	448	157

---

[1] Includes unemployed parent families and, for 1971–81, foster care children.

[2] Projection under current law.

Source: Office of Family Assistance and Office of Financial Management, Family Support Administration.

TABLE 22.—NUMBER OF AFDC RECIPIENTS, AND AS A PERCENTAGE OF VARIOUS POPULATION GROUPS

Calendar year	Total AFDC recipients	AFDC child recipients	Total population ages 0–17 [1]	AFDC recipients as a percent of total population [1]	AFDC child recipients as a percent of total child population	AFDC recipients as a percent of prewelfare poverty population [2]	AFDC child recipients as a percent of children in poverty [3]
1970	8,303	6,104	69,759	4.07	8.75	NA	58.5
1971	10,043	7,303	69,806	4.86	10.46	NA	69.2
1972	10,736	7,766	69,417	5.13	11.19	NA	75.5
1973	10,738	7,763	68,762	5.08	11.29	NA	80.5
1974	10,621	7,684	67,984	4.98	11.30	NA	75.7
1975	11,131	7,952	67,164	5.17	11.84	NA	71.6
1976	11,098	7,850	66,250	5.10	11.85	NA	76.4
1977	10,856	7,632	65,461	4.94	11.66	NA	74.2
1978	10,387	7,270	64,773	4.68	11.22	NA	73.2
1979	10,140	7,057	64,106	4.52	11.01	54.5	68.0
1980	10,599	7,295	63,694	4.66	11.45	49.2	63.2
1981	10,893	7,397	63,284	4.74	11.69	47.1	59.2
1982	10,161	6,767	62,953	4.38	10.75	40.6	49.6
1983	10,569	6,967	62,780	4.51	11.10	41.9	50.1
1984	10,645	7,017	62,773	4.50	11.18	43.6	52.3
1985	10,672	7,074	62,979	4.47	11.23	45.0	54.4
1986	10,850	7,206	63,302	4.50	11.38	46.6	56.0
1987	10,841	7,240	63,560	4.45	11.39	46.7	56.4
1988	10,915	7,328	63,820	4.44	11.48	48.5	58.8
1989	10,799	7,287	64,083	4.35	11.37	47.6	57.9

[1] Population numbers represent U.S. resident population, not including Armed Forces overseas. See table 7 in appendix M.

[2] Poverty population is determined by the number of people whose income (cash income plus social insurance plus Social Security before taxes and means-tested transfers) falls below the appropriate poverty threshold. This information can be found in appendix I, table 18.

[3] This information can be found in appendix I, table 2.

NA: Poverty population data is not available for this time period.

Note: In calculating the number of AFDC recipients, data for Guam, Puerto Rico, and the Virgin Islands was subtracted from the total AFDC population. Data for these territories was not available for 1970–76, so an estimate was used based on the ratio in later years (1977–87) of the number of recipients in these areas to the total number of recipients.

CHARACTERISTICS OF AFDC FAMILIES

This section describes the characteristics of AFDC families, using two main sources of data. For years through 1979, the sources were individual surveys of similar design specially conducted to gather information from agency case files. For 1982 and later years, data were derived from information collected from cases within the National Integrated Quality Control System's (NIQCS) monthly sample of cases.

Table 23 shows that the share of AFDC families with earnings fell more than 39 percent from March 1979 to 1989, from 12.8 percent to 8.5 percent. The share of families with no reported income other than AFDC climbed from 80.6 percent in 1979 to 87.8 percent in 1984, and fell to 79.5 percent by 1989. Moreover (table 25), the average amount of support contributed by stepparents (and in 1982 and thereafter deemed from them) more than doubled, from $63 per family in March 1979 to $157 in 1989.

Table 23 also shows the trend in other selected characteristics of AFDC families from 1969 to 1989. During this period, the average family size decreased from 4.0 persons to 2.9, the percent of families participating in the food stamp program increased, and the share of AFDC households with nonrecipient members climbed slightly.

Table 23 indicates that the share of AFDC families with no more than two children rose from 49.6 percent in 1969 to 71.1 percent in 1989, and the percentage of families reporting no father in the home rose from 84.7 percent in 1979 to 92.4 percent in 1989.

TABLE 23.—AFDC CHARACTERISTICS, 1969–89

	May 1969	January 1973	May 1975	March 1979	1983 [1]	1984 [1]	1986 [1]	1988 [1]	1989 [1]
Average family size (persons)	4.0	3.6	3.2	3.0	3.0	2.9	3.0	3.0	2.9
Number of child recipients (percent of AFDC cases):									
One	26.6	NA	37.9	42.3	43.4	44.1	42.7	42.5	41.8
Two	23.0	NA	26.0	28.1	29.8	29.6	30.8	30.2	29.3
Three	17.7	NA	16.1	15.6	15.2	15.5	15.9	15.8	15.4
Four or more	32.5	NA	20.0	13.9	10.1	10.0	9.8	9.9	9.6
Unknown		NA			1.5	.8	.8	1.7	3.9
Basis for eligibility (percent children):									
Parents present:									
Incapacitated	[2] 11.7	10.2	7.7	5.3	3.4	3.6	3.2	3.7	3.6
Unemployed	[2] 4.6	4.1	3.7	4.1	8.7	8.6	7.4	6.5	6.1
Parents absent:									
Death	[2] 5.5	5.0	3.7	2.2	1.8	1.9	1.9	1.8	1.9
Divorce or separation	[2] 43.3	46.5	48.3	44.7	38.5	38.2	36.3	34.6	34.0
No marriage tie	[2] 27.9	31.5	31.0	37.8	44.3	46.4	48.9	51.9	52.7
Other reason	[2] 3.5	3.6	4.0	5.9	1.4	1.2	2.4	1.6	1.7
Unknown					1.7				
Education of mother (percent of mothers): [3]									
8th Grade or less	29.4	NA	16.7	9.5	NA	NA	4.8	5.5	5.6
1–3 years of HS	30.7	NA	31.7	20.8	NA	NA	14.3	14.7	15.6
High School Degree	16.0	NA	23.7	18.8	NA	NA	17.3	18.1	17.5
Some College	2.0	NA	3.9	2.7	NA	NA	3.4	3.9	3.1
College Graduate	.2	NA	.7	.4	NA	NA	.5	.6	.4
Unknown	21.6	NA	23.3	47.8	NA	NA	59.7	58.3	55.4
Age of mother (percent of mothers):									
Under 20	6.6	NA	8.3	[4] 4.1	[4] 3.6	NA	[4] 3.3	[4] 3.4	[4] 3.8
20 to 24	16.7	NA	(5)	[6] 28.0	[6] 28.6	NA	[7] 33.6	[7] 32.2	[7] 32.0
25 to 29	17.6	NA	(5)	[8] 21.4	[8] 23.8	NA	[9] 20.0	[9] 19.4	[9] 25.0
30 to 39	30.4	NA	27.9	[8] 27.2	[8] 27.9	NA	[8] 30.1	[8] 31.5	[8] 31.6
40 or over	25.0	NA	17.6	[8] 15.4	[8] 15.7	NA	[8] 13.0	[8] 13.4	[8] 12.6
Unknown	3.6	NA	3.0	[8] 4.0	[8] 0.3	NA	0		
Ages of children (percent of recipient children):									
Under 3	14.9	NA	16.5	18.9	22.5	21.6	21.9	21.1	19.4
3 to 5	17.6	NA	18.1	17.5	20.1	21.0	21.1	21.0	21.4

TABLE 23.—AFDC CHARACTERISTICS, 1969–89—Continued

	May 1969	January 1973	May 1975	March 1979	1983 [1]	1984 [1]	1986 [1]	1988 [1]	1989 [1]
6 to 11	36.5	NA	33.7	33.0	31.5	31.9	32.4	33.3	32.2
12 and over	31.0	NA	30.9	29.8	25.5	25.5	24.3	22.4	21.8
Unknown		NA	.8	.9	.3	.2	.1	1.3	3.5
Mother's employment status (percent):									
Full-time job	8.2	9.8	10.4	8.7	1.5	1.2	1.6	2.2	2.5
Part-time job	6.3	6.3	5.7	5.4	3.4	3.6	4.2	4.2	3.4
Presence of income (percent families):									
With earnings	NA	16.3	14.6	12.8	5.7	6.0	7.5	8.4	8.5
No non-AFDC income	56.0	66.9	71.1	[10] 80.6	[10] 86.8	[10] 87.8	[10] 81.3	[10] 79.6	[10] 79.5
Median months on AFDC since most recent opening	23.0	27.0	31.0	29.0	26.0	26.0	27.0	26.3	24.9
Race (percent parents) [11]									
White	NA	38.0	39.9	40.4	41.8	41.3	39.7	38.8	38.4
Black	45.2	45.8	44.3	43.1	43.8	41.9	40.7	39.8	40.1
Hispanic	NA	13.4	12.2	13.6	12.0	12.8	14.4	15.7	15.9
Native American	1.3	1.1	1.1	1.4	1.0	1.1	1.3	1.4	1.3
Asian	NA	NA	.5	1.0	1.5	2.3	2.3	2.4	2.7
Other and unknown	4.8	1.7	2.0	.4	NA	.6	1.4	1.9	1.5
Incidence of households (percent):									
Living in public housing	12.8	13.6	14.6	NA	10.0	10.1	9.6	9.6	9.6
Participating in food stamp or donated food program	52.9	68.4	75.1	75.1	83.0	80.1	80.7	84.6	85.2
Including nonrecipient members	33.1	34.9	34.8	NA	36.9	36.9	36.7	36.8	36.7
Father's relationship to youngest child (percent):									
No father	NA	NA	NA	84.7	89.8	89.8	91.2	91.6	92.4
Natural father	NA	NA	NA	9.6	NA	NA	NA	NA	NA
Adoptive father	NA	NA	NA	.0	NA	NA	NA	NA	NA
Stepfather	NA	NA	NA	5.6	NA	NA	NA	NA	NA

---

[1] Data are for the Federal fiscal year October through September. All percentages are based on the average monthly caseload during the year. Hawaii and the territories are not included in 1983. Territories are not included in 1984, 1986, and 1987 data include Hawaii and the territories.

[2] Calculated on the basis of total number of families.

[3] For 1986 and 1987, education is for all AFDC adult recipients.

[4] Under age 19. Includes other caretaker adult if mother absent. Since 1986, the data are all for adult female recipients.

[5] The percentage for 20 to 29 year olds was 43.1.

[6] The ages were 19–24 in 1979 and 1983. Includes other caretaker adult if mother absent.

[7] Since 1986, the ages have been 19–25.

[8] Includes other caretaker adult if mother absent.

[9] Ages 26–29 in 1986, 1987 and 1988. Includes other caretaker if mother absent.

[10] State collected child support directly beginning in 1975, removing one source of non-AFDC income.

[11] For 1983, 12.6 percentage points where race was unknown were allocated proportionately across all categories. For 1984, 3.6 percent unknown were distributed proportionately within States reporting large proportions of unknown.

NA—Not available.

Source: Office of Family Assistance, Family Support Administration and Congressional Budget Office.

Table 24 presents data about the employment status of the AFDC mother (or other caretaker relative), and data about the tenure of the existing AFDC caseload.

The table indicates that the share of mothers (or other caretaker relatives) working full time declined from 8 percent in March of 1979 to 2.4 percent in 1989; the share working part-time fell from 5.0 percent to 4.5 percent in the same period. The share of mothers at school increased sharply between 1988 and 1989.

The table also indicates that the share of families who received benefits for more than 5 years (since the most recent opening of their case) did not change dramatically during the 1980s.

TABLE 24.—EMPLOYMENT STATUS OF AFDC MOTHERS AND TENURE OF AFDC FAMILIES, MARCH 1979, MAY 1982, FISCAL YEARS 1983, 1984, 1986, 1988, AND 1989 [1]

	Percent of total caseload						
	March 1979 [2]	May 1982 [3]	1983 [4]	1984 [4]	1986 [4]	1988 [4]	1989 [4]
Employment status of mother (or other caretaker):							
No mother (caretaker)	8.3	12.2	8.7	....	....	....	....
Full-time work, 35 or more hours per week	8.0	1.3	[5] 1.5	[5] 1.2	[5] 1.6	[5] 2.1	[5] 2.4
Part-time work, fewer than 35 hours per week	5.0	4.3	[5] 3.4	[5] 3.7	[5] 4.2	[5] 4.2	[5] 4.5
Incapacitated	6.0	NA	4.1	3.3	3.4	3.8	....
At school	2.6	NA	2.0	1.7	1.9	2.2	7.3
On layoff	.5	NA	.8	.4	.2	.2	.2
Seeking work	9.1	NA	NA	21.8	27.3	27.6	20.4
Other—needed at home or not actively seeking work	60.5	82.2	79.5	64.8	58.3	55.5	63.9
Unknown							1.9
Number of months on AFDC since most recent opening (percent of cases):							
1 to 6 months	16.4	20.0	18.9	18.1	17.2	18.2	18.3
7 to 12 months	12.5	12.4	13.1	12.8	12.6	13.2	13.6
13 to 24 months	16.7	16.2	16.6	17.8	17.2	17.3	18.3
25 to 36 months	11.4	12.6	12.0	11.4	11.8	11.2	11.4
37 to 60 months	15.3	14.2	15.4	16.2	14.9	15.0	14.5
61 plus months	26.9	23.5	23.7	23.4	25.9	24.9	23.9
Unknown	.8	1.1	.3	.1	.4	.2	.1

[1] See text about difference in data sources for 1979 and 1982.

[2] Source: Committee staff tabulation of March 1979 AFDC recipients' data base.

[3] Source: Office of Family Assistance, FSA.

[4] Fiscal year average monthly. 1983 does not include Hawaii or the territories. 1984 and 1986 data do not include the territories. 1987, 1988 and 1989 data include the territories and Hawaii.

[5] Full-time work, 30 hours or more per week; part-time work, fewer than 30 hours per week.

NA—Not available.

Table 25 presents data on income sources of AFDC families. It indicates that the share of AFDC families with earnings from the mother (or other caretaker relative) or from the spouse of the caretaker relative declined from 12.6 percent in March 1979 to 8.1 percent in 1989. Further, according to the table, the average monthly amount earned dropped in nominal terms from $382 to $296 for mothers with earnings; and from $323 to $309 for fathers (or spouses of caretaker relatives) with earnings.

TABLE 25.—INCOME SOURCES OF AFDC FAMILIES,[1] MARCH 1979,[2] MAY 1982,[3] FISCAL YEARS 1984, 1986, 1988, AND 1989

Income source	Percentage of caseload with income type						Average amount for those with income type					
	March 1979	May 1982	1984	1986 [4]	1988 [4]	1989 [4]	March 1979	May 1982	1984 [4]	1986 [4]	1988 [4]	1989 [4]
Earned income:												
Mother (or caretaker relative)	12.0	5.3	5.2	6.2	7.0	7.0	$382	$261	$245	$264	$276	$296
Father (or spouse of caretaker relative)	.6	.4	.6	1.0	1.1	1.1	323	244	270	271	316	309
Children (14+)	.1	(5)	.2	.3	.3	.5	206	398	237	323	299	668
Other adults	.1	NA	NA	.2	.2	.2	265	NA	NA	420	450	396
Public service	.1	NA	NA	NA	NA	NA	246	NA	NA	NA	NA	NA
OASDI	3.1	2.5	1.9	2.0	2.5	2.4	134	145	201	207	211	221
Veterans' benefits	.4	NA	NA	.2	.2	.2	128	NA	NA	139	122	141
Other government income	.4	.4	.4	.3	.3	.3	143	134	217	131	109	173
Unemployment compensation	.7	1.0	.7	.7	.6	.6	238	255	290	289	285	322
Workmen's compensation	.1	(4)	NA	.1	.1	.1	237	200	NA	299	267	348
Deemed income	.2	.3	NA	.1	.1	.1	63	159	NA	153	143	157
Contributions from other persons	.6	.9	NA	NA	1.3	1.6	72	79	NA	NA	92	100
Other cash income	1.9	2.5	[6] 2.9	[6] 2.0	2.0	2.1	81	251	103	128	83	74
SSI (Federal)	NA	NA	.7	3.0	1.9	1.3	NA	NA	302	334	369	440
Other public assistance or State SSI	NA	NA	.3	1.1	.8	.6	NA	NA	182	374	299	293
In-kind income	.4	NA	NA	NA	NA	NA	71	NA	NA	NA	NA	NA
Total	19.4	NA	12.2	18.7	20.4	20.5	299	NA	225	228	....	240

[1] See text about differences in data sources for 1979 and 1982.

[2] Source: Committee staff tabulation of March 1979 AFDC recipients' data base.

[3] Source: Office of Family Assistance, FSA.

[4] Fiscal year average monthly. 1984 and 1986 data do not include the territories. 1988 and 1989 data include both Hawaii and the territories.

[5] Less than 0.05 percent.

[6] Includes Federal SSI, State SSI, general assistance, income from assets and property and other unearned income.

NA—Not available.

Table 26 provides data on the share of AFDC families whose benefits were based on less than their gross cash income. That is, it summarizes information about disregarded (uncounted) income.

The table shows a decline in the share of families receiving the work incentive disregard (exclusion of the first $30 earned monthly plus one-third of the rest of earnings) betweem 1979 and 1982. It indicates that the average amount of child care costs disregarded declined from $101 monthly in March 1979 (for those with such costs) to $86 in May 1982, increased to $93 in 1984, and increased to $119 in 1989. The share of families receiving a child support disregard has increased.

TABLE 26.—INCOME OF AFDC FAMILIES NOT COUNTED BY THE PROGRAM,[1] MARCH 1979,[2] MAY 1982,[3] FISCAL YEARS 1984,[4] 1986, 1988, AND 1989

Disregards	Percent of caseload with disregard						Average amount for those with disregard					
	March 1979	May 1982	1984	1986	1988	1989	March 1979	May 1982	1984	1986	1988	1989
Optional $5 disregard	1.1	(5)	(5)	(5)	(5)	(5)	$6	(5)	(5)	(5)	(5)	(5)
$30 and one-third of earned income	12.5	[6] 2.5	2.1	3.8	4.1	4.0	147	[6] $62	$90	[7] $76	$77	83
Child care	3.9	1.3	1.0	1.5	1.7	1.7	101	86	93	106	114	119
Other work expenses	8.4	5.2	4.9	6.2	6.9	6.9	95	54	60	76	77	77
Cases with child care and other work expenses [8]	3.0	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	NA
Child support	.1	(9)	NA	3.0	4.7	5.1	93	NA	NA	[10] 47	[10] 48	48
Other	1.6	.4	NA	NA	NA	NA	77	100	NA	NA	NA	NA
Total	13.8	NA	5.0	6.3	7.0	7.0	250	NA	116	146	147	153

[1] See text about differences in data sources for March 1979 and May 1982.

[2] Source: Committee staff tabulation of March 1979 AFDC recipients' data base.

[3] Source: Office of Family Assistance, FSA.

[4] Average monthly for fiscal years.

[5] Repealed by 1981 law.

[6] Limited to 4 months' duration by 1981 law.

[7] $30 disregard extended for 8 months after end of $30 plus one-third by 1984 law.

[8] In these cases, there was insufficient information in the data file to distinguish between child care and other work expenses.

[9] Less than 0.05 percent.

[10] Average amount of $50 child support passthrough.

NA—Not available.

The AFDC recipient population is not a homogenous group of families or individuals, as illustrated in table 27. The table subdivides the 1989 AFDC caseload into seven mutually exclusive and exhaustive groups. Column one of the table contains data on the entire caseload. Column two of the table describes the AFDC units with no adult recipients. They represent 10.8 percent of the AFDC units and 7.5 percent of total payments. The average payment per case is $255 per month.

Columns 3–6 represent characteristics of the more typical AFDC units—one adult with children. The one adult caseload was split into four groups based on the reason for deprivation of the youngest child. Column three includes those cases with one adult for whom the reason for AFDC eligibility is that the other adult is absent because they are not married; these represent 49.3 percent of AFDC units.

The final two columns (columns seven and eight) of the table present characteristics of cases with two adult recipients. Column eight represents those cases where one parent is incapacitated, and column seven presents data on the unemployed parents (AFDC-UP) program caseload. In total, they represent about 6.7 percent of the total caseload and receive about 9.5 percent of the total payments. The cases where one parent is incapacitated tend to be older, as demonstrated by both the age of the mother and the age of the youngest child.

TABLE 27.—1989 AFDC CHARACTERISTICS [1]

			One adult				Two adult	
	Total	No adult	Not married	Divorced or legally separated	Not legally separated or divorced	Other reasons	Unemployed parent	Other
Number of families (in thousands) [1]	3,771	407	1,857	484	485	235	164	90
Percent of total	100.0	10.8	49.3	12.8	12.9	6.2	4.3	2.4
Average monthly payment	$372	$255	$364	$378	$403	$364	$601	$452
Percent of total dollars paid out	100.0	7.5	48.9	13.2	14.1	6.2	7.1	2.4
Average number in assistance unit	2.9	1.7	2.9	2.9	3.2	2.5	4.6	.1
Food Stamps:								
Percent participating	85.2	54.4	88.9	87.8	90.3	85.0	95.3	8.9
	Percentage Distribution							
Number of recipients:								
One	8.0	58.3	0.0	0.0	0.0	25.6	0.0	0.0
Two	37.2	25.1	46.1	39.0	30.1	34.7	0.0	12.4
Three	28.0	9.9	28.9	37.7	35.4	20.1	23.7	28.3
Four	15.9	4.6	15.5	16.5	21.5	11.2	31.3	25.7
Five	6.7	1.4	6.4	4.8	8.5	5.4	22.6	13.3
Six	2.5	.4	2.1	1.3	2.8	1.4	11.8	11.3
Seven or more	1.6	.2	1.0	.7	1.6	1.5	10.5	9.0
Number of nonrecipients:								
Zero	63.2	2.9	69.9	71.4	74.0	52.8	83.8	84.7
One	16.8	44.2	12.4	14.9	11.4	24.8	8.6	8.8
Two	9.4	24.7	7.6	7.1	7.5	11.0	4.3	3.8
Three or more	10.7	28.3	10.1	6.6	7.1	8.3	3.3	2.6

TABLE 27.—1989 AFDC CHARACTERISTICS [1]—Continued

	Total	No adult	One adult				Two adult	
			Not married	Divorced or legally separated	Not legally separated or divorced	Other reasons	Unemployed parent	Other
Shelter: [2]								
Owns or buying	4.7	7.8	2.0	7.5	4.7	7.8	10.4	14.2
Public housing	9.7	6.5	12.0	7.0	8.8	7.9	4.9	9.3
HUD rent subsidy	12.2	5.9	13.9	14.5	11.7	8.6	11.1	9.1
Other subsidy	1.8	1.3	1.8	2.6	1.6	1.9	1.1	2.5
Private housing	63.3	63.7	61.7	62.2	66.0	67.0	70.7	62.5
Rents free	6.6	12.5	6.8	4.6	6.0	5.4	1.4	2.2
Group quarters	1.6	2.3	1.9	1.6	1.2	1.4	.3	.2
Number of child recipients:								
Zero or one	45.7	59.1	48.9	39.6	31.8	51.2	27.6	47.4
Two	29.4	24.7	27.8	37.4	34.9	24.9	29.6	20.5
Three	15.4	10.0	14.2	16.3	20.8	13.4	21.3	14.1
Four or more	9.5	6.1	8.6	6.7	12.4	10.5	21.9	18.1
Race of caretaker:								
White	38.3	28.6	28.3	68.6	43.2	42.9	61.1	46.9
Black	40.3	43.4	54.0	14.9	30.4	30.4	8.1	15.7
Asion	2.7	2.6	1.1	1.3	1.9	6.9	19.6	9.2
Hispanic	15.9	20.2	14.1	12.6	22.1	17.0	9.3	25.8
American Indian	1.3	1.5	1.4	1.2	1.2	1.6	.9	.7
Unknown	1.5	3.8	1.0	1.4	1.2	1.7	.9	1.8
Age of youngest child in AFDC unit:								
Under 3	35.1	19.7	42.2	13.3	24.7	46.3	46.2	28.0
3 to 5	21.4	17.3	22.8	23.0	25.8	9.6	20.6	11.2
6 to 11	23.7	31.0	19.7	38.0	24.2	16.3	19.8	18.0
12 to 15	10.0	19.5	6.2	18.5	9.2	10.0	7.1	10.3
16 to 18	3.8	10.1	1.9	6.5	2.9	4.4	2.9	4.1
Unknown	6.0	2.3	7.1	.7	3.2	13.4	3.5	28.3
Number of months continuously on AFDC: [3]								
6 or less	18.3	15.9	15.4	13.8	23.4	30.4	19.6	22.5
7 to 12	13.6	12.5	13.6	13.8	16.1	11.4	12.9	13.0
13 to 18	10.2	10.4	10.3	9.7	11.3	7.5	11.7	9.5
19 to 24	18.1	8.1	8.1	8.6	7.6	7.1	8.5	8.0
25 to 36	11.4	10.3	11.5	13.1	10.9	9.8	12.6	10.7
37 to 48	8.3	9.0	8.3	8.7	7.3	8.0	7.3	9.6
49 to 60	6.3	6.5	6.7	5.9	5.2	5.0	8.0	5.9
61 to 120	16.8	18.0	17.7	16.4	13.5	13.9	18.0	17.4
121 to 180	4.9	6.3	5.8	3.8	3.2	4.3	1.2	2.7
181 and up	2.2	3.1	2.7	1.1	1.4	2.5	.1	.8
Age of female adult recipient: [4]								
11 to 18	3.4	NA	4.4	.5	1.5	6.5	2.8	2.2
19 to 21	12.0	NA	15.8	2.7	7.3	14.5	8.9	5.9
22 to 25	20.3	NA	23.2	13.2	19.2	17.4	17.7	13.2
26 to 29	20.1	NA	20.2	20.1	22.2	15.3	21.1	16.9
30 to 34	20.1	NA	18.3	27.2	22.4	14.9	20.2	19.8
35 to 39	11.7	NA	9.3	19.3	13.5	9.0	14.9	13.7
40 and up	12.4	NA	8.8	17.0	13.9	22.4	14.5	28.3

TABLE 27.—1989 AFDC CHARACTERISTICS [1]—Continued

	Total	No adult	One adult				Two adult	
			Not married	Divorced or legally separated	Not legally separated or divorced	Other reasons	Unemployed parent	Other
AFDC female adults employment status:								
Employed part-time	5.7	NA	4.6	9.6	5.0	4.7	7.0	7.7
Employed full-time	3.5	NA	3.2	4.8	4.2	2.0	2.9	4.7
Employed other	1.1	NA	0.8	2.1	1.2	0.6	0.8	0.8
Not employed	58.8	NA	61.8	46.1	58.9	65.2	56.7	64.2
Unemployed	30.9	NA	29.6	37.5	30.7	27.6	32.5	22.7
Percent with non-AFDC income	20.5	3.7	18.6	34.2	19.5	22.9	32.3	30.9
Average monthly amount of income [2]	$240	$241	$210	$232	$237	$248	$364	$355
Percent with earned income	8.5	.6	7.0	14.5	8.7	6.5	23.	13.5
Average monthly earned income [2]	$327	$332	$330	$335	$335	$345	$352	$362
Percent of earned income disregarded	46.8	69.0	58.3	44.5	49.2	38.6	37.8	36.5
Percent with unearned income	13.3	3.1	12.5	25.5	11.9	17.6	11.1	18.8
Average amount of unearned income [2]	$161	$222	$145	$132	$142	$196	$306	$322
Percent with countable assets	17.4	7.2	13.4	32.3	16.9	18.3	39.1	23.8
Income of persons not in assistance unit:								
Percent with income	44.8	90.8	23.1	26.7	19.4	50.8	28.3	19.5
Average monthly amount [2]	$498	$474	$511	$602	$617	$485	$583	$536
Percent with earned income	6.2	6.5	5.7	11.0	5.2	3.4	4.1	3.8
Percent with public assistance income	38.3	89.0	15.4	12.2	11.5	45.6	21.5	14.9
Percent with unearned income	9.6	18.1	5.3	6.6	4.6	13.7	5.3	1.6

[1] Data do not include characteristics for all AFDC cases. The number of missing cases is, unless otherwise stated, about 49,000 or 1.3 percent of the AFDC family caseload.

[2] Number of missing cases is about 75,000, or 2.0 percent of the AFDC family caseload.

[3] Number of missing cases is about 51,000, or 1.4 percent of the AFDC family caseload.

[4] Number of missing cases is about 556,000, or 14.7 percent of the AFDC family caseload.

NA—Not applicable.

Source: Family Support Administration.

Tables 28 through 31 present selected 1989 characteristics of the AFDC population by State. Table 28 presents selected demographic characteristics, including the number of persons in the AFDC unit and household, the percent of units with household members not in the unit, the percent of units with no adult recipients and with one adult recipient, and the percentage distribution of the units by age of youngest child and race of parent. Table 29 presents selected income characteristics, including the percent of units with earned income, unearned income, and various income disregards. This table also supplies the average monthly amount of these sources of income for those receiving them. Finally, table 29 provides information on the percent of units participating in the food stamp program. Table 30 provides a detailed percentage distribution of AFDC units by shelter arrangement. Table 31 provides a detailed percentage distribution of AFDC units by the reason for deprivation of the youngest child.

TABLE 28.—SELECTED DEMOGRAPHIC CHARACTERISTICS OF AFDC UNITS, BY STATE, OCTOBER 1988–SEPTEMBER 1989

State	Average number in unit	Average number in household of unit	Percent of units			Percentage distribution by age of youngest child [1]			Percentage distribution by race of natural/adoptive parent [1] [2]			
			With household members not in unit	With no adult recipient	With 1 adult recipient	0–2 yrs.	3–5 yrs.	6 or more yrs.	White	Black	Hispanic	Asian
Alabama	2.9	4.6	59.8	16.5	80.9	33.3	17.9	41.1	20.2	79.3	.1	.2
Alaska	2.6	3.4	35.5	6.7	88.8	34.2	24.9	36.7	50.8	8.3	2.6	1.0
Arizona	2.8	4.3	57.9	13.6	84.4	37.9	20.1	33.0	33.4	10.8	35.9	.7
Arkansas	2.9	4.5	61.6	17.1	81.2	29.2	23.5	39.7	32.3	66.7	.4	.4
California	3.0	4.1	49.9	14.2	72.6	39.9	22.2	36.0	33.9	23.1	28.2	10.3
Colorado	2.9	3.3	22.2	6.2	91.0	40.7	21.6	32.3	41.6	16.5	38.1	1.9
Connecticut	2.8	3.6	35.3	10.1	87.6	31.1	24.4	36.8	30.3	33.9	35.1	.6
Delaware	2.8	3.4	33.9	17.0	80.9	35.8	20.6	35.4	30.6	64.5	4.8	0
District of Columbia	2.7	4.0	57.6	13.3	85.3	34.0	20.3	38.5	.2	98.7	.9	0
Florida	2.7	4.1	59.5	23.2	75.3	37.8	20.4	33.3	27.6	59.5	12.4	.2
Georgia	2.9	3.9	43.5	15.0	83.4	31.5	20.5	38.0	20.1	79.5	.1	.2
Hawaii	3.1	3.6	23.6	9.8	74.3	31.4	22.8	39.1	24.5	1.3	2.9	69.5
Idaho	2.9	3.2	19.4	4.8	87.8	37.1	23.5	31.3	83.5	.6	9.0	1.0
Illinois	3.0	3.9	38.4	8.4	86.9	30.9	21.9	35.5	27.6	62.7	9.2	.5
Indiana	3.0	3.9	42.5	6.5	90.9	27.8	21.7	41.0	54.6	35.8	3.6	.2
Iowa	2.9	3.2	18.9	8.1	82.7	28.9	22.6	40.1	87.5	10.3	.9	.7
Kansas	3.0	3.6	32.6	10.2	78.2	30.6	23.0	36.3	64.2	28.2	3.7	2.3
Kentucky	2.7	3.8	50.9	14.6	83.7	24.9	20.5	47.9	78.3	21.3	0	.2
Louisiana	2.9	4.3	52.8	11.8	86.3	34.4	22.9	36.4	16.0	82.9	.3	.5
Maine	2.8	3.5	35.1	5.1	83.9	26.2	21.6	44.4	40.0	0	.2	0

TABLE 28.—SELECTED DEMOGRAPHIC CHARACTERISTICS OF AFDC UNITS, BY STATE, OCTOBER 1988–SEPTEMBER 1989—Continued

State	Average number in unit	Average number in household of unit	Percent of units			Percentage distribution by age of youngest child [1]			Percentage distribution by race of natural/adoptive parent [1] [2]			
			With household members not in unit	With no adult recipient	With 1 adult recipient	0–2 yrs.	3–5 yrs.	6 or more yrs.	White	Black	Hispanic	Asian
Maryland	2.8	3.8	51.4	10.8	86.9	36.7	22.0	35.1	27.2	69.8	1.0	.5
Massachusetts	2.9	3.2	21.1	5.9	88.8	38.8	22.1	33.9	52.4	17.0	22.2	5.5
Michigan	3.1	3.3	14.1	1.4	84.4	39.2	20.0	38.1	50.6	46.4	1.9	.5
Minnesota	3.1	3.5	26.4	3.5	82.9	38.1	23.7	34.8	70.8	14.4	3.2	4.9
Mississippi	3.1	4.5	54.0	13.8	85.7	30.9	21.7	39.8	13.2	86.5	.1	.1
Missouri	3.0	4.0	45.0	9.8	83.3	30.6	22.5	37.4	52.8	46.5	.5	.2
Montana	3.0	3.4	23.4	4.7	81.3	35.0	23.4	35.9	68.4	0	2.5	0
Nebraska	2.8	3.6	40.5	17.0	77.6	40.7	20.3	33.3	63.2	27.2	3.5	.4
Nevada	2.7	2.9	20.1	19.8	79.1	37.5	18.5	29.2	51.0	42.1	4.4	.3
New Hampshire	2.7	2.9	18.0	15.5	83.4	37.6	27.5	30.8	85.3	1.4	1.9	0
New Jersey	2.9	3.1	16.7	13.9	83.8	34.1	21.9	40.5	20.8	52.4	26.1	.4
New Mexico	2.9	3.5	31.1	10.4	86.5	33.7	23.8	37.0	21.1	5.8	58.0	.2
New York	2.9	3.0	3.5	4.8	86.5	35.2	21.5	33.2	24.1	35.4	36.8	.6
North Carolina	2.6	4.0	53.7	16.2	82.9	36.8	19.1	39.6	24.9	71.9	.6	.1
North Dakota	2.8	3.2	22.4	6.4	91.3	30.9	24.5	38.8	65.6	.6	.3	.3
Ohio	2.9	3.6	35.1	8.4	80.1	33.1	18.4	41.1	58.4	38.4	2.9	.1
Oklahoma	2.9	3.6	36.4	9.8	87.8	30.6	24.5	41.0	54.7	32.7	1.8	.3
Oregon	2.7	3.5	43.1	13.7	80.4	33.8	20.5	33.1	84.6	8.4	3.2	1.8
Pennsylvania	3.0	3.4	21.7	6.9	81.7	34.5	19.9	41.6	48.3	42.8	7.3	1.1
Rhode Island	2.8	3.1	17.9	5.1	92.2	41.7	21.9	34.7	61.9	14.6	17.5	4.6

South Carolina	3.0	4.6	58.7	19.6	78.4	35.1	22.0	40.2	17.2	82.1	.1	.2
South Dakota	2.9	3.8	37.0	10.1	87.9	41.8	21.2	30.3	46.5	1.0	0	.3
Tennessee	2.7	3.8	49.1	14.1	83.6	34.4	18.9	40.4	43.9	55.4	.2	.2
Texas	3.0	3.8	40.2	11.6	85.3	34.9	21.9	36.2	18.1	41.5	39.2	1.1
Utah	2.9	3.5	33.6	8.0	88.1	36.8	25.6	36.0	79.7	2.2	11.2	1.9
Vermont	2.9	3.2	18.8	3.4	81.2	31.2	21.9	41.6	98.5	.3	0	.6
Virginia	2.7	4.0	54.4	16.6	79.6	29.4	22.0	40.4	31.1	66.4	.7	1.6
Washington	2.8	3.6	39.8	10.9	76.8	40.3	22.9	34.0	73.2	10.6	5.4	5.5
West Virginia	3.0	3.7	35.5	9.3	66.9	28.9	20.9	45.7	92.1	7.6	0	0
Wisconsin	3.0	3.7	38.5	10.3	76.9	39.9	22.2	35.7	52.5	35.4	4.9	4.1
Wyoming	2.8	3.5	34.6	6.8	89.8	30.2	29.3	36.2	71.9	4.6	13.9	0
Guam	3.5	4.5	25.8	4.0	86.2	52.9	19.6	26.7	3.1	.4	.4	96.0
Puerto Rico	3.2	4.4	49.0	10.5	75.0	21.2	19.9	58.2	.2	.1	92.2	0
Virgin Islands	3.5	4.5	36.8	20.7	77.0	34.5	24.1	36.7	0	17.2	5.7	0
U.S. total	2.9	3.7	36.7	10.6	81.6	35.1	21.4	37.5	38.4	40.1	15.9	2.7

---

[1] Percentages will not add to total as "unknown" and "other" not included.

[2] All race categories are mutually exclusive.

Source: "Characteristics and Financial Circumstances of AFDC Recipients, 1989." U.S. Department of Health and Human Services.

TABLE 29.—SELECTED INCOME CHARACTERISTICS OF AFDC UNITS, BY STATE, OCTOBER 1988–SEPTEMBER 1989

State	Units with earned income		Units with unearned income		Units with income disregarded for child care		Units that have $30 plus one-third disregard		Percent of units participating in the food stamp program [2]
	Percent of total units	Average monthly amount (dollars) [1]	Percent of total units [1]	Average monthly amount (dollars) [1]	Percent of units with earned income	Average monthly amount (dollars) [1]	Percent of units with earned income	Average monthly amount (dollars) [1]	
Alabama	3.7	115.04	11.8	84.93	11.1	71.40	35.6	46.12	87.9
Alaska	14.1	543.77	15.3	361.08	6.8	193.33	59.1	133.85	63.3
Arizona	7.0	265.08	3.3	110.45	20.8	105.62	73.3	83.49	90.4
Arkansas	4.6	217.91	16.9	70.24	20.0	99.22	60.0	68.07	82.3
California	9.6	474.81	13.8	297.47	15.9	151.91	31.4	90.09	75.7
Colorado	10.7	279.37	14.0	150.74	28.6	127.01	47.1	75.11	89.0
Connecticut	5.8	390.78	15.2	231.83	15.3	154.69	45.9	126.62	76.5
Delaware	5.5	274.11	23.6	74.87	16.7	100.00	66.7	64.17	84.5
District of Columbia	2.5	314.06	7.2	216.11	18.8	73.33	62.5	98.20	67.4
Florida	6.1	256.25	11.5	84.07	21.3	67.71	55.0	67.98	77.6
Georgia	6.7	246.59	23.2	129.79	25.6	95.86	46.3	69.89	79.7
Hawaii	11.1	436.81	6.3	292.87	7.5	47.00	58.5	142.45	83.3
Idaho	16.5	329.67	21.3	204.76	23.5	121.25	51.0	58.69	87.1
Illinois	5.9	281.16	11.3	150.44	37.1	150.27	45.1	74.94	91.8
Indiana	10.2	182.75	30.4	97.71	13.5	79.12	37.3	63.17	81.2
Iowa	18.8	245.36	20.3	78.33	28.3	105.11	42.9	77.55	87.9
Kansas	11.9	286.40	9.6	111.73	10.0	77.36	63.6	96.84	84.1
Kentucky	5.3	179.56	4.4	146.85	17.5	101.40	49.1	54.37	86.7
Louisiana	4.4	178.96	12.3	88.06	13.5	106.43	63.5	60.88	93.3
Maine	21.2	331.57	25.9	195.87	30.6	115.59	27.6	90.84	85.3

Maryland	5.3	281.71	13.1	81.65	28.9	126.32	51.6	80.24	89.3
Massachusetts	5.9	343.16	21.9	135.03	27.4	72.45	49.3	100.97	84.4
Michigan	15.8	390.24	19.3	185.47	17.1	135.20	48.9	90.00	93.5
Minnesota	15.8	374.66	21.7	122.20	34.9	135.79	56.6	117.33	84.2
Mississippi	13.4	290.52	16.2	104.38	17.3	105.86	56.8	77.96	90.9
Missouri	8.7	231.83	14.7	82.87	21.3	84.81	54.8	68.22	87.5
Montana	14.7	222.62	19.4	164.71	21.3	109.30	44.7	48.10	91.3
Nebraska	15.3	250.73	7.2	201.55	10.0	115.00	47.1	80.79	89.3
Nevada	5.0	219.22	10.7	84.10	16.7	182.00	72.2	72.92	78.2
New Hampshire	8.2	357.50	21.8	127.72	10.0	71.33	66.7	127.40	76.6
New Jersey	3.6	265.76	3.0	195.74	20.0	111.89	31.1	79.14	84.5
New Mexico	5.0	194.08	12.4	151.27	33.3	60.62	75.0	63.17	88.8
New York	4.5	297.42	13.9	156.79	17.5	110.00	42.1	71.58	95.2
North Carolina	11.8	319.20	20.4	99.33	16.3	119.54	54.4	96.82	67.3
North Dakota	16.6	233.74	33.5	73.83	29.8	92.35	43.9	63.44	82.5
Ohio	6.6	316.58	9.5	95.44	15.2	108.17	55.7	104.25	89.5
Oklahoma	7.8	256.62	7.7	154.24	3.9	60.67	67.1	82.71	84.5
Oregon	13.5	265.99	16.1	101.09	32.7	129.91	56.1	69.07	90.1
Pennsylvania	8.9	276.68	3.8	189.43	23.9	114.12	48.6	83.83	91.2
Rhode Island	9.3	348.92	24.2	269.80	31.4	109.44	60.8	88.06	91.1
South Carolina	11.5	293.76	17.9	112.17	14.4	70.47	55.3	88.34	79.4
South Dakota	17.8	253.72	31.6	61.54	26.4	101.93	35.8	79.68	81.8
Tennessee	11.1	280.59	10.8	129.04	28.1	103.82	58.3	73.23	89.4
Texas	4.9	185.41	7.6	77.89	23.3	106.34	68.4	49.94	93.8
Utah	19.2	286.80	17.7	104.38	14.6	69.60	51.5	72.32	87.5

TABLE 29.—SELECTED INCOME CHARACTERISTICS OF AFDC UNITS, BY STATE, OCTOBER 1988–SEPTEMBER 1989—Continued

State	Units with earned income		Units with unearned income		Units with income disregarded for child care		Units that have $30 plus one-third disregard		Percent of units participating in the food stamp program [2]
	Percent of total units	Average monthly amount (dollars) [1]	Percent of total units [1]	Average monthly amount (dollars) [1]	Percent of units with earned income	Average monthly amount (dollars) [1]	Percent of units with earned income	Average monthly amount (dollars) [1]	
Vermont	14.5	270.04	21.3	162.46	8.5	92.50	46.8	66.68	86.7
Virginia	7.3	220.93	10.8	238.70	0.7	23.00	48.0	77.59	81.4
Washington	10.5	327.19	11.8	214.71	20.0	132.82	48.0	90.42	88.6
West Virginia	6.5	178.39	17.7	79.00	*	*	41.2	72.48	91.5
Wisconsin	18.6	317.65	20.4	129.94	27.5	110.27	51.6	77.99	81.6
Wyoming	16.7	217.28	12.3	116.25	18.5	108.70	68.5	68.59	91.7
Guam	0.9	115.00	7.6	59.35	*	*	50.0	30.00	70.7
Puerto Rico	0.6	157.36	2.6	55.65	*	*	63.6	44.86	41.2
Virgin Islands	*	*	4.6	148.25	*	*	*	*	83.9
U.S. total	8.5	$327.20	1.3	$161.23	20.1	$119.38	47.5	$82.91	85.2

NA—No case samples available.

[1] Average amount for those with the income source or income disregard.

[2] Unknown category was distributed proportionately within States reporting proportions of unknown.

Source: "Characteristics and Financial Circumstances of AFDC Recipients, 1989", U.S. Department of Health and Human Services.

TABLE 30.—AFDC FAMILIES BY TYPE OF SHELTER ARRANGEMENT—OCTOBER 1988–SEPTEMBER 1989

State	Total families	Owns or is buying	Public housing	HUD rent subsidy	Other rent subsidy	Private housing (no subsidy)	Shares group quarters	Rents free	Unknown
Alabama	44,820	7.2	20.7	12.8	.4	27.9	1.4	29.1	.6
Alaska	7,415	7.3	11.8	7.3	5.4	50.8	1.3	16.0	0
Arizona	36,044	2.3	8.0	13.5	2.1	63.9	.7	9.6	0
Arkansas	23,914	5.8	11.6	22.3	.5	35.0	4.1	20.7	0
California	604,761	1.1	2.6	7.7	.8	86.2	1.4	0	.1
Colorado	33,851	1.0	7.7	20.0	5.7	60.1	4.1	1.4	.2
Connecticut	38,311	1.3	16.9	23.0	1.6	49.8	5.3	2.2	0
Delaware	7,462	1.8	10.9	20.6	.6	61.5	3.0	1.5	0
District of Columbia	18,126	1.3	17.1	13.8	5.3	58.2	2.2	.9	1.3
Florida	118,582	1.5	8.7	14.0	.8	70.0	1.0	4.0	0
Georgia	92,654	4.6	17.9	11.7	1.6	40.3	3.0	12.1	8.7
Hawaii	13,873	2.1	9.4	16.5	2.5	47.5	11.1	10.9	0
Idaho	6,198	5.8	3.9	19.4	6.1	52.9	2.6	7.1	2.3
Illinois	206,895	3.1	13.4	6.8	.9	69.7	1.3	4.7	0
Indiana	51,611	3.9	9.1	12.8	5.0	63.9	.1	4.9	.4
Iowa	34,819	8.1	1.8	17.7	1.6	63.7	4.2	2.8	0
Kansas	25,213	5.9	6.1	10.4	.3	70.7	.6	5.9	0
Kentucky	58,717	11.3	9.2	11.6	.5	57.3	.1	8.6	1.4
Louisiana	92,194	5.4	14.6	14.1	.6	34.1	6.2	25.0	0
Maine	17,948	17.4	.2	6.5	14.1	43.1	0	2.5	16.3
Maryland	63,230	1.6	11.1	11.2	1.3	72.3	.5	1.4	.6
Massachusetts	88,187	1.5	12.9	23.5	8.0	50.0	3.5	.7	0
Michigan	211,919	14.5	2.3	8.1	1.3	69.5	.1	4.0	.2
Minnesota	54,639	10.2	10.5	22.0	2.9	51.1	.1	2.0	1.3
Mississippi	59,860	8.1	4.3	20.3	.7	25.8	.3	40.0	.5
Missouri	68,040	6.5	5.4	17.6	.7	57.1	.6	7.9	4.2
Montana	9,329	5.3	12.5	26.2	5.9	44.7	4.4	.9	0
Nebraska	14,210	3.5	9.2	25.1	3.9	51.9	4.6	1.7	.2
Nevada	7,292	0	7.7	25.9	0	44.6	0	21.8	0
New Hampshire	4,901	2.7	13.1	12.3	3.8	58.0	7.1	2.7	.3
New Jersey	102,519	1.2	7.8	7.5	1.9	78.6	1.9	1.0	0
New Mexico	20,372	11.8	10.6	24.4	2.1	38.5	4.1	8.5	0
New York	337,300	.8	15.0	6.7	2.6	73.6	.2	1.3	0
North Carolina	77,066	1.3	15.4	13.9	1.3	61.6	2.0	4.4	0
North Dakota	5,489	8.7	18.7	23.3	19.2	20.7	2.6	6.7	0
Ohio	222,187	5.2	8.2	16.3	1.4	65.2	.6	3.1	0
Oklahoma	35,930	5.5	5.2	25.1	2.6	34.8	7.8	18.7	.3
Oregon	32,060	3.0	8.6	19.2	1.1	63.0	4.1	1.0	0
Pennsylvania	174,577	4.2	14.1	5.4	1.6	71.7	2.0	.8	.2
Rhode Island	15,057	3.1	15.5	18.8	.7	54.5	4.4	2.9	.2

TABLE 30.—AFDC FAMILIES BY TYPE OF SHELTER ARRANGEMENT—OCTOBER 1988–SEPTEMBER 1989—Continued

State	Total families	Owns or is buying	Public housing	HUD rent subsidy	Other rent subsidy	Private housing (no subsidy)	Shares group quarters	Rents free	Unknown
South Carolina..	37,466	8.0	7.9	18.8	.1	26.3	.9	33.7	4.3
South Dakota...	6,632	5.4	4.4	18.5	19.2	40.7	2.7	9.1	0
Tennessee.........	70,574	4.5	21.0	13.9	1.0	50.2	.7	8.8	0
Texas................	181,598	5.1	11.1	20.0	2.0	34.5	.6	26.7	0
Utah.................	14,969	3.2	.6	20.1	2.4	70.1	.6	3.0	0
Vermont...........	7,015	10.8	12.3	6.8	.6	55.2	8.6	4.3	1.2
Virginia.............	53,918	2.3	18.2	14.5	.8	39.8	4.0	8.6	11.8
Washington......	78,031	3.7	5.9	12.8	2.5	73.4	.4	1.3	0
West Virginia....	36,087	14.7	6.7	16.5	.5	48.4	1.8	11.4	0
Wisconsin.........	81,981	5.8	5.0	9.8	2.0	70.2	3.1	4.1	.1
Wyoming..........	5,122	22.2	8.0	9.3	1.5	53.7	2.2	2.8	.3
Guam...............	1,170	3.6	0	52.9	2.2	15.6	.9	24.9	0
Puerto Rico......	57,841	31.9	23.4	3.2	2.1	20.0	3.3	15.8	.3
Virgin Islands...	941	13.8	62.1	0	1.1	10.3	1.1	11.5	0
U.S. total.....	3,770,918	4.7	9.6	12.1	1.8	62.9	1.6	6.5	.7

Source: "Characteristics and Financial Circumstances of AFDC Recipients, 1989." U.S. Department of Health and Human Services.

TABLE 31.—AFDC FAMILIES BY REASON FOR DEPRIVATION OF THE YOUNGEST CHILD, OCTOBER 1988–SEPTEMBER 1989

State	Parent deceased	Parent incapacitated	Parent unemployed	Parent absent			Other	Unknown
				Divorced or legally separated	Not legally separated	Not married		
Alabama..............................	2.5	3.5	0	11.4	11.9	62.8	7.6	.3
Alaska.................................	3.2	4.2	0	22.4	10.2	49.5	7.0	3.5
Arizona...............................	1.6	2.8	0	15.1	19.8	55.1	3.4	2.1
Arkansas..............................	.8	3.2	0	14.6	13.1	65.9	2.1	.3
California............................	2.6	3.2	10.9	15.9	15.9	45.9	1.9	3.6
Colorado..............................	1.0	3.2	0	23.5	15.2	47.9	1.6	7.7
Connecticut..........................	1.9	1.2	1.2	10.8	15.3	64.0	3.3	2.4
Delaware..............................	2.1	1.8	.3	11.2	11.5	69.7	2.1	1.2
District of Columbia............	1.3	.3	.8	2.8	8.5	81.5	1.3	3.6
Florida................................	1.6	1.0	0	10.6	17.8	63.9	2.8	2.3
Georgia...............................	2.1	1.9	0	11.0	15.6	67.2	1.3	.9
Hawaii.................................	2.3	9.0	5.0	15.1	14.6	51.3	1.0	1.7
Idaho..................................	1.3	1.3	.3	25.8	20.3	41.0	3.9	6.1
Illinois................................	1.0	1.2	3.7	9.7	13.5	68.5	.7	1.6
Indiana................................	1.8	3.0	0	24.5	9.0	60.8	.9	.1

TABLE 31.—AFDC FAMILIES BY REASON FOR DEPRIVATION OF THE YOUNGEST CHILD, OCTOBER 1988–SEPTEMBER 1989—Continued

State	Parent deceased	Parent incapacitated	Parent unemployed	Parent absent			Other	Unknown
				Divorced or legally separated	Not legally separated	Not married		
Iowa	1.0	4.2	6.2	30.7	12.9	44.2	.6	.2
Kansas	1.0	3.6	6.5	26.3	11.8	46.1	2.7	2.2
Kentucky	1.7	13.6	0	19.4	18.8	45.7	.8	0
Louisiana	1.9	3.2	0	8.6	10.5	71.7	2.7	1.4
Maine	.9	6.0	5.1	29.2	14.4	42.5	.9	.9
Maryland	1.0	1.5	.9	6.1	13.2	74.0	.8	2.5
Massachusetts	2.9	2.6	2.5	12.7	17.6	55.7	2.3	3.6
Michigan	1.5	1.1	8.8	17.5	9.7	51.8	1.5	8.0
Minnesota	1.4	2.3	11.0	23.1	11.3	47.0	1.1	3.0
Mississippi	1.4	2.0	0	9.0	16.2	70.6	.6	.3
Missouri	1.4	3.5	5.3	17.5	15.6	55.4	1.1	.3
Montana	0	2.5	11.9	28.4	8.4	45.0	1.6	2.2
Nebraska	.4	2.0	4.1	20.0	12.0	53.2	2.4	5.9
Nevada	.8	1.4	0	18.2	17.6	58.4	0	3.6
New Hampshire	.5	1.4	0	23.7	19.9	49.0	3.0	2.5
New Jersey	2.5	.8	1.4	9.0	15.5	69.4	1.0	.5
New Mexico	2.5	3.9	.6	19.7	18.8	46.2	3.7	4.6
New York	2.1	2.0	2.5	7.5	18.5	52.6	1.2	13.6
North Carolina	1.3	1.9	.2	8.8	17.8	67.3	.6	2.2
North Dakota	.9	3.5	0	38.5	6.7	43.1	5.5	1.7
Ohio	1.4	2.7	8.5	18.1	12.7	49.6	1.7	5.3
Oklahoma	1.0	3.3	0	28.6	17.1	48.1	1.8	.1
Oregon	.8	3.1	3.9	21.2	16.9	50.0	2.4	1.7
Pennsylvania	1.5	3.9	3.5	11.9	19.2	56.1	1.9	2.0
Rhode Island	1.5	2.7	1.1	18.8	12.4	57.2	2.4	4.0
South Carolina	1.2	2.2	.8	6.6	22.4	66.2	.5	.2
South Dakota	1.0	2.0	0	25.9	9.8	58.9	1.7	.7
Tennessee	1.1	4.6	0	13.4	14.4	56.9	2.1	7.4
Texas	1.5	3.5	0	12.5	17.5	61.2	3.4	.2
Utah	.2	5.4	.2	25.9	21.1	39.9	1.5	5.8
Vermont	1.2	9.6	5.2	23.5	12.0	42.9	1.5	4.0
Virginia	1.3	4.1	0	9.5	17.0	66.7	1.1	.2
Washington	1.5	3.9	9.4	20.4	16.9	41.9	3.0	3.0
West Virginia	1.6	6.3	21.4	16.1	21.5	31.8	.8	.4
Wisconsin	1.4	2.5	10.0	19.4	7.2	52.6	1.2	5.7
Wyoming	1.5	1.9	.9	37.0	14.5	42.0	1.2	.9
Guam	1.3	2.2	4.0	15.1	.9	69.3	4.0	3.1
Puerto Rico	2.5	14.1	0	12.3	24.8	43.6	2.6	.2
Virgin Islands	1.1	3.4	0	4.6	9.2	80.5	0	1.1
U.S. total	1.8	3.0	4.6	14.3	15.4	55.4	1.8	3.8

Source: "Characteristics and Financial Circumstances of AFDC Recipients, 1989". U.S. Department of Health and Human Services.

LENGTH OF TIME ON WELFARE AND TURNOVER WITHIN THE AFDC CASELOAD

LENGTH OF TIME ON WELFARE

Average length of time on welfare.—A 1983 study of AFDC families[2] found that although most "spells" of AFDC are relatively short, most persons enrolled in the program at any point in time are in the midst of spells that last at least 8 years. As the first two columns of table 32 illustrate, the study reported that 50 percent of AFDC spells lasted less than 2 years and 62 percent lasted less than 4 years. At the same time, the study reported that 50 percent of the persons enrolled at a point in time were in the midst of very long episodes (8 or more years) of AFDC receipt, and such long-term recipients used most of the resources of the program.

The 1983 study has since been updated by one of its authors, because it understated the extent of long-term welfare dependence by neglecting to take into account the fact that multiple spells of welfare receipt are common (about one-third of all welfare spells are followed by subsequent spells). Accounting for multiple spells alters the distribution of total expected time on welfare, as the last two columns of table 32 illustrate. The fact remains, however, that while a significant percent of all persons on welfare will be enrolled for less than 2 years (30 percent) or less than 4 years (50 percent), a majority of persons enrolled in AFDC at a point in time are in the midst of what will be long periods of welfare receipt (65 percent).

TABLE 32.—DISTRIBUTION OF LENGTH OF TIME ON AFDC

[In percent]

Expected time on AFDC	Single spell analysis		Multiple spell analysis	
	Persons beginning a spell	Persons on AFDC at a point in time	Persons beginning first AFDC spell	Persons on AFDC at a point in time
1 to 2 years	48	14	30	7
3 to 4 years	14	10	20	11
5 to 7 years	20	25	19	17
8 or more years	17	50	30	65
All	100	100	100	100

This seemingly paradoxical finding that there are large differences between point-in-time and ever-began estimates of welfare dependency highlights a crucial element of welfare dynamics that is characteristic of the dynamics of spells of poverty and unemployment as well. The differences in the estimates occur because the probability of being on welfare (or being poor or unemployed) at a given time is necessarily higher for longer-term recipients than for those who have shorter welfare spells. Thus, the point-in-time welfare sample is a biased sample of *all* welfare recipients.

---

[2] Bane, Mary Jo, and Ellwood, David T., The Dynamics of Dependence: The Routes to Self-Sufficiency. Prepared for the U.S. Department of Health and Human Services under contract No. HHS-100-82-0038, June 1983. (Prepared by Urban Systems Research and Engineering, Inc., Cambridge, Mass.)

An example of spells of hospitalization will help to establish this point. Consider a 13-bed hospital in which 12 beds are occupied for an entire year by 12 chronically ill patients, while the other bed is used by 52 patients, each of whom stays exactly 1 week. On any given day, a hospital census would find that about 85 percent of patients (12/13) were in the midst of long spells of hospitalization. Nevertheless, viewed over the course of a year, short-term use clearly dominates: out of the 64 patients using hospital services, about 80 percent (52/64) spent only 1 week in the hospital. Exactly the same dynamic accounts for the results with regard to welfare experience. One of the most important lessons from the longitudinal evidence is that while the welfare population at any point in time is composed predominantly of long-term users, the typical recipient is a short-term user.

Subgroup analysis of length of time on welfare.—Tables 33 and 34 present data on the length of time on welfare for various subgroups of the population. Table 33 is based on ever-began estimates of welfare receipt which take into account multiple spells. This table shows that the most powerful predictor of long-term welfare receipt is marital status. Single women average 9 years of AFDC receipt, and 39 percent are predicted to receive AFDC for 10 or more years. Race and work experience also seem to distinguish themselves among different subgroups of AFDC recipients. Blacks and those who did not work in the 2 years prior to their first receiving welfare are estimated to average over 8 years of AFDC receipt, and nearly one-third of each group are expected to receive AFDC for 10 or more years. Education may well be another important grouping: high school graduates seem to fare better than dropouts. However, these education-related estimates are less reliable because the sample size of those with less than 9 years of education is very small.

Table 34 presents another approach to evaluating length of time on welfare. It takes a sample of the entire 1975 population, and chronicles welfare receipt patterns for the next 10 years. Eighty-seven percent of this 1975 sample lived in families in which no AFDC income was received in the following 9 year period, 1975–1984. Fewer children (78.0 percent) received no AFDC. This table also presents data on individuals for whom AFDC and Food Stamps together constituted 50 percent of their family's annual income. Only 4.0 percent of all non-white Americans and 0.4 percent of all white Americans in this group were on welfare 8 to 10 years out of the total 10-year period. Note that these data do not describe the welfare receipt patterns of the population in anything but this 10-year window. Years of welfare receipt prior to and after this period are not accounted for. Thus, these data represent a lower bound estimate of long-term receipt.

TABLE 33.—PERCENTAGE OF AFDC RECIPIENTS WITH VARIOUS CHARACTERISTICS AND AVERAGE TOT~~AL DURATI~~ONS OF AFDC RECEIPT

Recipient characteristics at time of first spell beginning	Percent of all first-time recipients (new beginnings)	Percent of recipients at any point in time [1]	Average number of years of AFDC receipt	Percent who will have AFDC spells of 10 or more years
Age:				
Under 22	30.0	35.9	8.23	32.8
22 to 30	40.7	41.9	7.08	25.8
31 to 40	11.8	8.8	5.15	15.0
Over 40	17.6	13.4	5.23	15.8
Race/ethnicity:				
White	55.2	47.7	5.95	19.6
Black	40.1	47.4	8.14	32.0
Other	4.8	4.8	6.94	25.5
Years of education:				
Under 9	9.7	9.6	6.81	24.5
9 to 11	37.6	41.9	7.65	29.2
Over 11	52.7	48.5	6.33	21.8
Marital status:				
Single	29.5	40.0	9.33	39.3
Divorced	28.1	20.2	4.94	13.7
Separated	32.3	31.9	6.80	24.4
Widowed	8.4	5.3	4.37	10.2
Number of children:				
0 to 1	43.4	48.7	7.71	29.7
2 to 3	42.8	37.3	6.04	20.1
Over 3	13.8	13.7	6.83	24.5
Age of youngest child:				
Under 3	51.3	60.4	8.09	31.9
3 to 5	22.5	22.3	6.79	24.2
6 to 10	19.7	12.9	4.51	11.3
Over 10	6.5	4.4	4.71	12.4
Work experience:				
Worked in the last 2 years	65.8	59.6	6.53	23.0
Did not work in the last 2 years	34.2	39.8	8.00	31.2
Disability status:				
No disability	81.6	81.4	6.85	24.8
Disability limits work	18.4	18.6	6.97	25.0

[1] These figures assume that the AFDC caseload is a "steady state."

Source: David T. Ellwood. "Targeting Would-Be Long-Term Recipients of AFDC," Table IV–1. Simulation model estimates are based on the 15-year panel study of income dynamics. For each individual who began a first spell on or after the third sample year of the PSID, probabilities are predicted for exiting from first spell, for recidivism, and for exiting from later spells, based on logic models.

TABLE 34.—WELFARE DEPENDENCY, 1975–84, BY TWO DEFINITIONS OF DEPENDENCY

[In percent]

Years on welfare	Fraction living in households in which at least $1 of AFDC was received by head or wife			Fraction living in households receiving AFDC in which AFDC of head and wife plus food stamps was at least 50 percent of total family income		
	All	Children, age 0 to 5 in 1975	Women, age 18 to 55 in 1975	All	Children, age 0 to 5 in 1975	Women, age 18 to 55 in 1975
All races:						
0 years	86.6	78.0	88.6	92.8	85.1	94.5
1 to 2 years	6.5	8.0	5.9	3.6	5.2	2.8
3 to 7 years	4.9	7.7	4.0	2.8	6.6	2.1
8 to 10 years	2.0	6.4	1.6	1.0	3.0	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
White:						
0 years	90.5	84.4	91.7	95.7	90.6	96.5
1 to 2 years	5.5	7.0	5.0	2.3	2.9	2.0
3 to 7 years	2.8	3.8	2.4	1.5	4.7	1.3
8 to 10 years	1.2	4.6	0.8	0.4	1.7	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Nonwhite:						
0 years	61.9	44.9	67.2	74.8	56.8	80.8
1 to 2 years	12.2	12.7	11.7	11.4	17.0	8.4
3 to 7 years	18.2	27.2	15.0	9.8	16.4	8.1
8 to 10 years	7.7	15.2	6.1	4.0	9.8	2.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table reads: 86.6 percent of the population lived in households in which no AFDC income was received during the 1975–84 period.

Source: Special tabulations of the Panel Study of Income Dynamics by Greg J. Duncan, 1988.

INTERGENERATIONAL "DEPENDENCY"

Intergenerational welfare dependency has been examined by researchers. Using data from the Panel Study of Income Dynamics, Hill and Ponza found in 1984 that most daughters in welfare-dependent families did not become welfare-dependent as young adults. As table 35 illustrates, only 19 percent of black daughters and 26 percent of white daughters in highly dependent welfare families became highly dependent themselves. It is also interesting to note that fully 42 percent of the black daughters and 27 percent of the white daughters who grew up in families which were heavily dependent on welfare received *no* welfare as young adults.

TABLE 35.—INTERGENERATIONAL TRANSMISSION OF WELFARE DEPENDENCY

Parental welfare status	Status of daughters as young adults: Received no welfare (percent)	Low welfare dependence	High welfare dependence	Total (percent)	Number of observations
Received no welfare:					
Black	53	33	14	100	108
White	79	19	2	100	354
Low welfare dependence:					
Black	31	49	20	100	130
White	63	31	5	100	75
High welfare dependence:					
Black	42	39	19	100	92
White	27	47	26	100	25

Note.—"High Welfare Dependence" is defined as receiving at least 25 percent of average family income as cash welfare payments. Parental measures are typically averaged over 7 years during the time the child is 10 to 16 years old. Measures on the children as young adults are typically measured over 7 years during the time the child is 24 to 30 years old.

Source: Hill, Martha S., and Ponza, Michael. "Does Welfare Dependency Beget Dependency?" Institute for Social Research, Fall 1984. Mimeo.

Source of data: Panel Study of Income Dynamics.

TURNOVER WITHIN THE AFDC CASELOAD

To further understand the dynamics of welfare receipt, data are available which describe which events in an individual's life provide the explanation for beginnings and endings of spells of AFDC receipt.

Beginnings of AFDC spells.—As table 36 illustrates, three-fourths of all spells in the PSID data set began with a relationship change that created a female-headed family with children. Almost half the AFDC spells started after a wife became a female family head (by loss of the male head and his earnings due to absence, divorce, separation, death). Another 30 percent began when a never-married, divorced, or separated woman acquired a child.

In contrast to changes in family composition, changes in earnings were a relatively minor cause of resorting to welfare. Only 15 percent of AFDC spells could be traced to a drop in family earnings.

Endings of AFDC spells.—The most common route out of AFDC was by way of a change in family structure. Some 46 percent of endings occurred this way—35 percent when a female head became a wife and 11 percent when the household no longer contained a child under 18.

Increased earnings were much more significant in ending AFDC than decreased earnings were in starting it. Some 26 percent of endings occurred this way—21 percent when the female head herself earned more money and 5 percent when another member of the family increased earnings.

Poverty status.—About 40 percent of those who ended AFDC spells were poor after their exit. About 52 percent of those whose AFDC eligibility ended because they no longer had an eligible child were poor in the following year. For those who earned their way off AFDC, about 32 percent were poor in the year after their welfare spell; their poverty reflected the sub-poverty gross income eligibility limits of AFDC in many States.

TABLE 36.—EVENTS ASSOCIATED WITH THE BEGINNINGS AND ENDINGS OF AFDC SPELLS

Beginnings	Percent	Endings	Percent
Divorce/separation	45	Marriage	35
Childless, unmarried woman becomes a female head with children.	30	Children leave parental home	11
Earnings of female head fell	12	Earnings of female head increased.	21
Earnings of others in family fell	3	Earnings of others in family increased.	5
Other income fell	1	Transfer income increased	14
Other (including unidentified)	9	Other (including unidentified)	14
All	100	All	100

Sources: "Beginnings": Bane and Ellwood (1983), p. 18, using PSID data. "Endings": Ellwood (1985), p. 46, using PSID data.

WELFARE AND OTHER SOURCES OF SUPPORT FOR ADOLESCENT MOTHERS

Young mothers, like all young adults, are in the process of making a transition from childhood to adulthood and eventual self-sufficiency. In this process, the young mother relies on a changing mix of private resources and, in many cases, public assistance to support herself and her family.

One of the subgroups at greatest risk for long-term welfare receipt is comprised of young never-married women who enter the AFDC program when their child is less than 3 years old. For example, it is estimated that over 40 percent of never-married women who enter the AFDC system at age 25 or less with a child less than 3 years old will spend 10 years or more on AFDC.[3] This subsection provides data on the number of teenage mothers in the United States and the proportion receiving AFDC, and presents data on some of the dynamics of their welfare receipt.

Number of Teenage Mothers.—There are several different estimates of the number of teenage mothers in the United States. Probably the best estimates are based on data from the National Center for Health Statistics (NCHS). These are shown in table 37 below for 1983.

---

[3] Ellwood, David T. "Targeting 'Would-Be' Long-Term Recipients of AFDC," prepared for the U.S. Dept. of Health and Human Services under contract No. 100–84–0059, June 1986. (Prepared by Mathematica Policy Research, Inc.)

TABLE 37.—NUMBER OF TEENAGE MOTHERS IN THE UNITED STATES BY CURRENT AGE AND AGE AT BIRTH OF FIRST CHILD, 1983

Current age	Total	Unmarried at time of first birth	Age at first birth	Total	Unmarried at time of first birth
Under 15	10,234	9,583	Under 15	58,860	54,320
15	33,798	30,215	15	117,811	100,792
16	82,425	68,889	16	195,333	151,725
17	162,949	127,065	17	227,039	160,670
18	256,161	183,695	18	195,041	124,142
19	361,801	633,231	19	113,284	61,029
Total	907,368	652,678		907,368	652,678

Source: Based on data from NCHS annual natality reports, 1978–83.

Preliminary NCHS data indicate that the number of teenage mothers had fallen to 907,368 by 1988, of which 652,678 were unmarried.

Private Sources of Income.—A young mother has three potential sources of private income: her parents or relatives, the father of her children, and her own earnings. The private resources that a young mother has access to depend heavily on her marital status and living arrangements. Although the maritial status and living arrangements of young mothers tend to change over time, more than 90 percent of young mothers in the Current Population Survey (March 1986 and 1987) fell into one of three combinations: 42 percent were married and living with their husbands and children; 28 percent were single and living with their parents or other relatives; and 21 percent were single and living with their children in their own homes. Each of these groups rely on different sources of income for their economic well-being.

Those mothers living at home or with relatives likely benefit from the household income and may, in some cases, contribute to the family's income themselves. Young mothers living alone appear to be less able to support themselves and their children than older mothers who delayed childbearing.

Young mothers may also receive support from their husband or the absent father of their children. The amount of support available from husbands varies by the husbands' characteristics—such as age, employment status, and level of educational attainment. Studies suggest that roughly half of absent fathers maintain contact with their children and that many provide both financial aid and in-kind resources such as food, clothing, and child care, particularly during the first few years after their children are born. Some absent fathers also pay court-mandated child support payments, although mothers who were never married are much less likely to receive such aid—and get smaller payments when they do—than are their counterparts who were previously married. Furthermore, the low levels of support provided by some absent fathers may be related to their own inadequate resources. These fathers tend to have less education, to have higher unemployment rates, and to rely on parents or other relatives for their own support.

The Dynamics of Welfare Receipt Among Teenage Mothers.—Because adolescent mothers often have limited private resources, many of them receive public assistance, primarily AFDC, during their first few years of motherhood.

Data from AFDC quality control records indicate that in 1983 the average monthly number of teenage mothers receiving AFDC was 236,000. Of these teenage mothers on AFDC, 199,000 were unmarried. Data from AFDC records suggest that by 1986, the number of teenage mothers had fallen to roughly 213,000, of which 172,000 were unmarried. Of these teenage mothers on AFDC in 1986, 52.3 percent were 19, 31.1 percent were 18, 10.5 percent were 17, 4.4 percent were 16, and the remainder were 15 and younger.

An examination of data from the National Longitudinal Survey of Youth (NLSY) reveals patterns of young mother's entries into and exits from the AFDC program. Table 38 describes the probability that an adolescent mother will begin to receive AFDC within the first 48 months after the birth of her first child.[4] Of these adolescents who had their first child between 1979 and 1985,[5] about 27 percent reported receiving welfare at some point within the 12 months following the birth of that child. This proportion increased slightly to 30 percent in the fourth year (37 to 48 months after birth).

Adolescent mothers who were unmarried at the time of the birth of their first child were much more likely to receive welfare than were those teenage mothers who were married when they gave birth. Approximately 48 percent of the unmarried mothers received welfare for at least one month in the first year after the birth of their first child, compared with roughly 7 percent of those who were married when they gave birth.

Both groups of young mothers were slightly more likely to receive welfare 13 to 24 months after giving birth than in the first 12 months after birth. As might be expected, mothers who were unmarried when they gave birth continued to be much more likely to receive welfare—namely, 49 percent of the unmarried mothers reported at least one month of welfare receipt 13 to 24 months after giving birth compared with about 8 percent of the married adolescents.

Although the differences in the recipiency rates of the two marital status groups are likely to be due to a number of factors, it is useful to recognize that marriage directly affects the eligibility of the young mother. Married couples are likely to have higher incomes than are unmarried adolescent mothers and thus are less likely to need or to qualify for benefits. In addition, many States did not operate AFDC-UP programs during this period; therefore, married couples, where the principal earner was unemployed, could not receive AFDC benefits.

---

[4] In this table, adolescent mothers are defined as those who were between the ages of 15 and 19 when they had their first child. The mothers examined here had their first children between 1979 and 1985.

[5] Through the AFDC-Unemployed Parent (AFDC-UP) program, States had the option to provide benefits to married couples where the principal earner is unemployed. In 1983, for example, 29 States did not provide AFDC-UP benefits—meaning that a married couple would not be eligible for assistance unless one was incapacitated. The Family Support Act of 1988 now requires States to operate an AFDC-UP program.

Mothers who were 15 to 17 years old when they gave birth were slightly more likely to report being on welfare in the first 12 months after birth (29 percent) than were 18- to 19-year-old mothers (26 percent). This difference becomes larger during the subsequent 12 months (13 to 24 months after giving birth), when the proportion of younger adolescent mothers who report receiving welfare in at least one month increased to 32 percent, while that of older adolescent mothers stayed fairly steady at 25 percent.

TABLE 38.—ADOLESCENT MOTHERS RECEIVING AFDC

[In percent]

Characteristics of mother	Time between birth and receipt of AFDC (months)			
	0 to 12	13 to 24	25 to 36	37 to 48
All	27	28	29	30
Marital status at birth of first child:				
Married	7	8	12	14
Unmarried	48	49	50	49
Age at birth of first child all mothers:				
15 to 17	29	32	39	38
18 to 19	26	25	23	24
Mothers who were unmarried when they first gave birth:				
15 to 17	45	49	57	52
18 to 19	51	49	42	44
Race:				
All mothers:				
White	21	21	22	23
Black	42	46	50	47
Mothers who were unmarried when they first gave birth:				
White	52	49	45	47
Black	46	51	56	52

Source: Congressional Budget Office tabulations of data from the National Longitudinal Survey of Youth (1979-1985).

Notes.—Adolescent mothers are defined as all women who first gave birth when they were between the ages of 15 and 19.

These findings are based on relatively small samples and therefore should be taken as indicative of general patterns of behavior rather than as precise estimates, particularly for the period furthest from the birth.

The differences in the welfare recipiency patterns of adolescent mothers of different ages could be due to a number of factors. In particular, they are likely to be partially due to marital status differences between the two groups—the younger mothers in this sample were much less likely to be married than were older mothers. Other factors that might play a role include differences in living arrangements and in the likelihood of having a subsequent birth.

THE FAMILY SUPPORT ACT OF 1988

On October 13, 1988, the Family Support Act of 1988 (Public Law 100–485) was signed into law. The major elements of the JOBS, child care transition, and Medicaid transition programs are summarized in table 39.

TABLE 39.—IMPORTANT ELEMENTS OF JOBS AND THE TRANSITIONAL CHILD CARE AND MEDICAID PROGRAMS

Important elements of JOBS:

Funding provisions	Federal Match rates: 90 percent for $126 million (equal to 1987 WIN funding); AFDC benefit match rate with a floor of 60 percent for most expenditures (the highest state benefit match in 1989 will be 80 percent); AFDC benefit match rate for child care; 50 percent for most administrative costs and other services. Entitlement caps (excluding child care).

[Fiscal year, in millions of dollars]

1989	600
1990	800
1991	1,000
1992	1,000
1993	1,000
1994	1,100
1995	1,300
1996 and after	1,000

Work-related activities	States must include these activities: education, job skills training, job readiness, job development and job placement. States must include two of the following activities: group and individual job search, on-the-job training, work supplementation, community work experience or other approved work experience.
Priority groups	States must spend 55 percent of their funds on: (1) Recipients or applicants who have received AFDC for any 36 of the preceding 60 months. (2) Parents under age 24 who have not completed high school or had little or no work experience in the preceding year. (3) Members of families whose youngest child is within two years of being ineligible for AFDC. States must give priority to volunteers within these three groups.

Participation requirements:

[Fiscal year, in percent]

General:

1990[1]	7
1991	7
1992	11
1993	11
1994	15
1995	20

TABLE 39.—IMPORTANT ELEMENTS OF JOBS AND THE TRANSITIONAL CHILD CARE AND MEDICAID PROGRAMS —Continued

	[Fiscal year, in percent]	
	AFDC–UP:	
	1994	40
	1995	50
	1996	60
	1997	75
	1998	75
Important elements of the Transitional Child Care Program:		
Funding provisions	Uncapped entitlement at AFDC benefit match rate (50 percent to 80 percent).	
Eligibility	Families who leave AFDC because of increased earnings, hours of work, or loss of the earnings disregards. Families must have received AFDC in at least three of the preceding six months. No income limits.	
Benefits	Direct child care services, vouchers, cash, reimbursements, or other arrangements adopted by state agency. Care must meet state and local standards. Last for 12 months.	
Maximum payments	Reimbursements are limited to actual costs, up to local market rates. States may set payment maximums below market rates. These caps may not be less than the AFDC child care disregards of $175 a month for children two years and older and $200 a month for children under age two unless local market rates are lower than these levels..	
Family copayments	Vary with family's ability to pay as determined by states in sliding scale formulas.	
Effective dates	Program begins April 1, 1990. Program ends September 30, 1998.	
Important elements of the Transitional Medicaid Program:		
Funding provisions	Uncapped entitlement at Medicaid match rate (50 percent to 80 percent).	
Eligibility	Families who leave AFDC because of increased earnings, hours of work, or loss of the earnings disregards. Families must have received AFDC in at least three of the preceding six months. Families whose average gross monthly earnings (less necessary child care expenses) are below 185 percent of the poverty thresholds.	
Benefits	Last for 12 months. Second six months are contingent on payment of a premium, which is at state option.	
Premiums	States allowed to charge a premium after six months to families whose average gross monthly earnings (less necessary child care expenses) are above the poverty thresholds. Premiums limited to no more than 3 percent of a family's average gross monthly earnings.	
Effective dates	Program begins April 1, 1990. Program ends September 30, 1998.	

---

[1] There is no penalty for not meeting the 1990 requirements.

Source: Congressional Budget Office.

CBO ANALYSIS OF COST AND IMPACT OF THE FAMILY SUPPORT ACT OF 1988 [6]

Cost

New Federal Government costs projected under the act will total $3.3 billion over the 5-year period from fiscal years 1989 through 1993. The act includes funding provisions primarily dealing with the recovery of debts owed the Federal Government and changes in the dependent care credit under the income tax system. Revenues and receipts from the funding provisions will balance the added spending and leave the projected Federal deficit essentially unchanged over the 5 years (see table 40).

Also, as shown in table 40, the bill will add new projected costs of $0.7 billion to State and local governments. This is one-fifth of Federal Government costs. Moreover, States will be affected very differently by the act, depending on whether they already have an AFDC-Unemployed Parent program and on the size of their existing work-related programs.

TABLE 40.—COST SUMMARY OF MAJOR PROVISIONS OF FAMILY SUPPORT ACT OF 1988

[Fiscal year, in millions]

	1989	1990	1991	1992	1993	Total 1989–93
Federal costs (CBO estimates):						
JOBS Program:						
Establish JOBS	33	242	357	277	167	1,076
Add mandatory participation rates			45	75	45	165
Other	0	1	7	6	2	18
Transitional assistance:						
Reimburse child care for 12 months after leave AFDC		25	205	245	260	735
Provide Medicaid for 12 months after leave AFDC		5	105	155	165	430
AFDC–UP Program:						
Mandate AFDC–UP [1]			315	397	441	1,153
Child support enforcement:						
Mandate income withholding			−25	−55	−90	−170
Mandate child support guidelines		−25	−70	−115	−160	−370
Other	5	12	56	38	30	141
Miscellaneous:						
Expand earnings disregards		30	45	45	45	165
Other	24	23	−16	−30	−39	−38
Total outlays	62	313	1,024	1,038	866	3,305

---

[6] This section is based entirely upon a CBO staff working paper entitled "Work and Welfare: The Family Support Act of 1988," January 1989.

TABLE 40.—COST SUMMARY OF MAJOR PROVISIONS OF FAMILY SUPPORT ACT OF 1988—Continued

[Fiscal year, in millions]

	1989	1990	1991	1992	1993	Total 1989–93
Revenues (Joint Committee on Taxation estimates):						
IRS debt collection	400	400	400	400	400	2,000
Restrict child care tax credit to children < 13 (current law < 15)	9	86	90	93	97	375
Taxpayer id no. required of service provider to obtain child care credit	37	102	121	132	137	529
Other	27	90	97	105	111	430
Total revenues	473	678	708	730	745	3,334
State and local costs:						
JOBS Program:						
Establish JOBS	−4	−63	−133	−158	−169	−527
Add mandatory participation rates			30	50	35	115
Other	0	0	1	1	1	3
Transitional assistance:						
Reimburse child care for 12 months after leave AFDC		15	120	145	150	430
Provide Medicaid for 12 months after leave AFDC		5	85	125	135	350
AFDC–UP Program:						
Mandate AFDC–UP [1]			232	294	323	849
Child support enforcement:						
Mandate income withholding			−25	−65	−105	−195
Mandate child support guidelines		−35	−85	−135	−180	−435
Other	−1	−2	18	−3	−22	−10
Miscellaneous:						
Expand earnings disregards		47	57	57	62	223
Other	13	−6	−29	−38	−40	−99
Total outlays	8	−39	271	273	190	704

[1] Includes two related provisions, one of which allows States to amend the "quarters of work" rule and a second which requires demonstrations of the 100-hour rule.

Source: Congressional Budget Office and Joint Committee on Taxation.

THE 1987 AMENDMENTS

In December of 1987, Congress enacted H.R. 3545, the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203). This new law includes four AFDC amendments, which are summarized below:

1. Fraud control under AFDC program.—Effective April 1, 1988, authorizes 75 percent Federal funding for the costs of a State's fraud control program.

2. Assistance to Homeless Families.—Prohibits the Secretary of Health and Human Services, prior to October 1, 1988, from taking any action that would have the effect of implementing, in whole or in part, the proposed regulations published in the *Federal Register* on December 14, 1987. These regulations would have restricted the use of AFDC emergency assistance funds for homeless families and would have limited States' authority to make payments for special needs of AFDC recipients. The moratorium on promulgation of regulations is intended to give Congress an opportunity to determine whether and how the current AFDC statute should be amended to respond to the problems of homeless families.

3. Washington State Demonstration Program.—Allows the State of Washington to conduct a demonstration of its proposed Family Independence Program.

4. New York State Demonstration Program.—Allows the State of New York to test a child support supplement demonstration program as an alternative to the present AFDC program.

THE 1984 AMENDMENTS

In June of 1984, Congress enacted H.R. 4170, the Deficit Reduction Act of 1984 (Public Law 98-369). This new law, which took effect on October 1, 1984, includes 22 AFDC amendments and an income and asset verification amendment which affected several programs, and are summarized below:

1. Gross income limitation.—Under prior law, eligibility for AFDC was limited to families with gross incomes at or below 150 percent of the State standard of need. The act increases the gross income limitation to 185 percent of the State standard of need.

2. Work expense deduction.—Under prior law, States were required to disregard the first $75 of monthly earnings for full-time work expenses; a lower deduction applied to part-time workers. The act requires States to disregard the first $75 monthly for full and part-time workers.

3. Continuation of $30 disregard.—Under prior law, the $30 plus one-third of remaining earnings disregard was limited to 4 months. The act retains the 4-month limit on the one-third disregard but extends the $30 disregard for an additional 8 months for a total of 12 months.

4. Work transition status.—Under prior law, a family who lost AFDC eligibility due to the 4-month limit on the earnings disregard, simultaneously lost categorical eligibility for Medicaid. The act provides that families who lose AFDC because of the termination of the earnings disregard will be eligible for 9 months of Medicaid coverage. At State option, an additional 6 months of Medicaid coverage can be provided. In addition, families who lost AFDC eligibility prior to enactment of the work transition will also be eligible for Medicaid under certain specified circumstances.

5. Clarification of earned income provisions.—The act clarifies that the term "earned income" as used in the AFDC program means the gross amount of earnings, prior to the taking of payroll or other deductions.

6. Burial plots, funeral agreements and certain property.—Under prior law, burial plots and funeral agreements were counted toward the $1,000 asset limit. The act exempts from the AFDC resources limitation, burial plots and funeral agreements. An AFDC policy on real property that is similar to SSI policy is also established.

7. Federal matching for Community Work Experience Program (CWEP) expenses.—Under prior law, States were required to reimburse a CWEP participant for necessary transportation and other expenses. Federal matching for this reimbursement was by regulation, limited to $25 per month. The act requires States to reimburse a CWEP participant for costs incurred if the State is unable to provide directly any transportation or day care services. Reimbursement of day care expenses is limited to those determined by the State to be reasonable, necessary and cost effective up to $160 per month per child.

8. Retrospective budgeting and monthly reporting.—Under prior law, monthly reporting and retrospective budgeting were required for all AFDC cases; however, the Secretary of Health and Human Services could waive the monthly reporting requirement if it was not cost effective to require the report. The act mandates retrospective budgeting for cases filing a monthly report. Monthly reporting is required when cost effective; cases with earned income and recent work history must report monthly.

9. Earned income tax credit (EITC).—Under prior law, States were required to assume that an individual was receiving the earned income tax credit on an advance basis regardless of when or if it was received. The act requires States to count the EITC only when actually received.

10. Demonstrations of one-stop service delivery.—The act authorizes from 3 to 5 Federally-assisted demonstration projects designed to test the effectiveness and efficiency of integrating the delivery of human services.

11. Work requirements for pregnant women.—The act adds to those who are exempt from work registration, any woman who is in the third trimester of pregnancy.

12. Recalculation of lump sum income.—Under prior law, States could only recalculate ineligibility due to receipt of lump sum income if a life threatening circumstance occurred. The act allows States to recalculate the ineligibility period under other specified circumstances. Ineligibility may be recalculated if: (1) an event occurs which would have changed the amount of AFDC paid; (2) the income becomes unavailable for reasons beyond the family's control; and/or (3) the family incurs, becomes responsible for and pays medical bills which offset the lump sum income.

13. Overpayment recoupment.—Under prior law, States were required to attempt to recover all benefit overpayments. The act permits States to waive overpayment recovery when it is not cost effective. States will be permitted to automatically waive overpayments of less than $35. Larger overpayments must be collected unless the State determines, after attempting to collect the overpayment, that the cost to collect would exceed the amount owed.

14. Protective payments.—Under prior law, States were required to make protective payments to a third party when a parent on AFDC failed to meet certain statutory procedural requirements. The act permits States to make the payment to the parent if, after all reasonable efforts have been made, a suitable protective payee cannot be found.

15. Eligibility requirements for aliens.—Under prior law the income of an individual who sponsors a non-refugee alien was deemed to be available to the alien for 3 years after entry into the United States. The act establishes a similar policy for aliens who are sponsored by organizations or agencies.

16. Fugitive felons.—The act permits States to disclose the current address of an AFDC recipient if a law enforcement agency provides the correct social security number and demonstrates that the recipient is a fugitive felon.

17. Payment schedule for back claims.—The act establishes a payment schedule for court-ordered reimbursements and certain other back claims owed by the Federal Government to the States that have been allowed or are pending.

18. Work supplementation program.—The act modifies the existing work supplementation program to provide additional flexibility to States in operating grant diversion programs in which all or part of the AFDC grant can be used to subsidize a job.

19. Disregard of in-kind income.—The act extends, until October 1, 1987, the disregard of certain in-kind assistance provided on the basis of need.

20. Standard filing unit/child support payments.—There was no requirement in prior law that parents and all siblings be included in the AFDC unit. The act requires States to include in the filing unit the parents and all minor siblings living with a dependent child who applies for or receives AFDC. In addition, a monthly disregard of $50 of child support received by a family is established.

21. CWEP work for Federal agencies.—The act permits Federal agencies or offices to serve as community work experience program (CWEP) sites under the same requirements as apply to other sites.

22. Earned income of full-time students.—For purposes of applying the gross income limitation, the act allows States to disregard the income of an AFDC child who is a full-time student.

23. Income and eligibility verification procedures.—Under present law, IRS wage information furnished by employers to IRS is available to State welfare agencies for use in their AFDC and food stamp programs, and to the Social Security Administration for administering the SSI program. However, IRS unearned income information (filed by a financial institution or corporation with respect to payments to individuals in the form of interest, dividends, etc.) is not available to Federal and State agencies for use in the administration of these programs. Quarterly wage information from the unemployment compensation program is available to State welfare agencies in most States.

Public Law 98-369 provides for the IRS to disclose return information with respect to unearned income to Federal, State, or local agencies administering AFDC, SSI, Medicaid, food stamps, and the cash assistance programs administered in Puerto Rico, Guam, and the Virgin Islands.

Disclosure can only be made to agencies that meet the requirements to safeguard this confidential information against disclosure, and verification of the unearned income information is required prior to taking action to reduce or terminate benefits.

The provision also replaces existing statutory provisions relating to use (for purposes of AFDC) of return and other wage information and use of social security numbers, by adding a new section to the Social Security Act requiring States to have in effect an income and eligibility verification system for use in administering the AFDC, Medicaid, unemployment compensation, and food stamp programs (and the adult assistance programs in the territories). State agencies must request and make use of: (1) wage and other income information available under the Internal Revenue Code; and (2) quarterly wage information. Each State is required as of September 30, 1988, to maintain a quarterly wage reporting system, although not necessarily through its unemployment compensation system.

The income and eligibility system requires use of standardized data formats to facilitate exchange of information, for the purpose of identifying and reducing ineligibility and incorrect payments.

IMPACT OF 1981 PROGRAM CHANGES

The Omnibus Budget Reconciliation Act of 1981 (OBRA) imposed a gross income limit for AFDC eligibility (150 percent of a State's need standard), capped the deduction for child care costs ($160 monthly per child), set a standard deduction for other work expenses ($75 monthly), and ended the work incentive disregard for working recipients after their first 4 months on a job. These provisions affected AFDC parents with jobs by reducing or ending their benefits. They also had potential effects on welfare mothers without jobs by reducing the gains possible from work, and on nonwelfare mothers with low earnings. Under previous law, a person in the latter group could increase total income by decreasing or ending earnings, enrolling in AFDC, and then resuming work. OBRA also required States to count part of the income of a stepparent as available to an AFDC child.

Former HHS Assistant Secretary Rubin reported in testimony that 408,000 families lost eligibility and 299,000 lost benefits as a result of the OBRA changes. The changes saved the Federal and State governments about $1.1 billion in 1983. This implies an average loss in benefits per family of $1,555 per year.

GAO evaluation of the 1981 amendments

At the request of the House Ways and Means Committee, the U.S. General Accounting Office conducted an in-depth evaluation of the effect of the 1981 amendments on individual AFDC families in five cities: Boston, Dallas, Memphis, Milwaukee, and Syracuse. GAO examined case records, analyzed 10 years of HHS program data, and interviewed former working AFDC recipients more than a year after their termination from AFDC due to the 1981 amendments.

Findings include:

—Once the declines in caseload and outlays stabilized, OBRA had decreased the national AFDC-basic monthly caseload by 493,000 cases and monthly outlays by $93 million. However, because the caseload rose faster than predicted after this point, long-term effects are less certain.

—Working AFDC recipients who lost eligibility due to the OBRA cuts were more likely to be non-white, younger than those who remained on AFDC (28–33) and had been working for their current employer between 1.7 and 3.4 years.

—Recipients who lost AFDC eligibility suffered a substantial loss of income which they could not make up by increased earnings or other means. The average *monthly* income loss for working single parent families who lost AFDC eligibility was $186 in Memphis, $229 in Dallas, $180 in Milwaukee, $151 in Syracuse, and $115 in Boston.

—A large number of families interviewed had fallen below the poverty level after the OBRA changes were implemented. This ranged from a high of 85.5 percent of families below poverty in Memphis to a low of 28 percent of the Milwaukee families interviewed in poverty.

—Lack of health coverage was common among these former AFDC recipients. In Dallas, 59.2 percent of those families who lost AFDC did not have any health coverage. In Memphis, 45 percent, in Boston 27.5 percent, in Syracuse, 17.1 percent and in Milwaukee, 13.9 percent had no health coverage at all. Private health insurance coverage was more common in high AFDC benefit States.

—Families terminated from AFDC were more likely to face increased emergency situations. In several sites, significantly more families had to forgo medical treatment or were refused medical and/or dental treatment because they could not pay. It was also more common for these families to run out of food before the end of the month, have to seek food from a church or charity group, or need to borrow $50 or more from friends or relatives to meet expenses. In all but one site, those terminated from AFDC said they are eating worse now than before.

Section 8. Child Support Enforcement Program

BACKGROUND

The enactment of the Child Support Enforcement (CSE) program in 1975 represented a major new commitment on the part of the Congress to address the problem of nonsupport of children. Although prior to that time the Social Security Act had included provisions which were aimed at improving the collection of support on behalf of children with absent parents, these provisions had not proved to be effective. The 1975 amendments were aimed at strengthening in a very significant way the efforts of the Federal and State Governments to improve the enforcement of child support obligations.

The 1975 legislation (Public Law 93-647) added a new part D to title IV of the Social Security Act. The statute, as amended, authorizes Federal matching funds to be used for enforcing the support obligations owed by noncustodial parents to their children and the spouse (or former spouse) with whom the children are living, locating absent parents, establishing paternity, and obtaining child and spousal support. Basic responsibility for administering the program is left to the States, but the Federal Government plays a major role in funding, monitoring and evaluating State programs, providing technical assistance, and in certain instances, in giving direct assistance to the States in locating absent parents and obtaining support payments from them. The program requires the provision of child support enforcement services for both welfare and nonwelfare families and requires States to publicize frequently, through public service announcements, the availability of child support enforcement services, together with information about the application fee and a telephone number or address to be used to obtain additional information.

PROGRAM TRENDS

Table 1 summarizes child support enforcement program trends since 1978. In 1990, $1.6 billion was spent to collect $6.0 billion. A sum of $3.76 was collected for every $1 of administrative expense. This was up by 33 percent from the low point of only $2.89 per dollar of administrative expense in 1982. Also, 391,000 paternities were established; 2,057,000 absent parents were located; 1,018,000 support obligations were established; collections were made for an average of 2,062,000 cases, 239,000 families were removed from AFDC because of child support collections; and slightly over 10 percent of AFDC payments were saved as a result of child support enforcement.

Table 2 compares various measures of the effectiveness of the child support enforcement program between administrative data and census data. The first four rows of table 5 are from the Office of Child Support Enforcement and illustrate huge increases in total constant dollar collections, the number of absent parents located, and paternities and awards that were established between 1978 and 1987.

The bottom portion of the table based on census data presents an entirely different picture of the effectiveness of the child support enforcement program. For example, rather than having total real collections increase by 117 percent, it shows that total collections increased by only 22 percent in real collections between 1978 and 1987. Other measures of effectiveness from census data illustrate a similar picture.

One possible explanation for this different picture is that the official child support enforcement statistics are capturing collections that were being made anyway. Since income from census survey data tends to be underreported on household surveys, the truth may lie somewhere in between. To receive AFDC, mothers have had to assign their child support collections to the AFDC agency. As a result, another problem with survey data is that AFDC mothers included in the CPS survey may not be able to distinguish what portion of their AFDC check represents a child support collection from an absent father and what portion represents an AFDC benefit.

The terms in table 2 from the Census are defined as follows. The term "demographically eligible" includes all women who are living with children under 21 years of age whose natural fathers are not living in the household. This includes ever-divorced (including remarried) or currently separated women. The percent with awards are the women with court-ordered payments. The reason the percent "supposed to receive payment" is different from the percent with awards is that some mothers awarded payments were not due them for the year in question.

DEMOGRAPHIC TRENDS

A sizable and growing proportion of American households are families that consist only of a mother and her children. Between 1970 and 1990, the number of female-headed families with children under 18 has increased by 131 percent; the number of such two-parent families has declined 4 percent. As a result, by 1989 more than one out of every five children under 18 in the United States lived in a family where the mother was never married or the father was absent because of death, divorce, or separation. An unprecedented number of children live in single-parent homes, many without adequate or any support from the other parent.

TABLE 1.—PROGRAM OPERATIONS, SUMMARY OF NATIONAL (FEDERAL AND STATE) STATISTICS, FISCAL YEARS 1978–90

[Numbers in thousands, dollars in millions]

	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Total child support collections	$1,047	$1,333	$1,478	$1,630	$1,770	$2,024	$2,378	$2,696	$3,246	$3,917	$4,613	$5,250	$6,035
In 1987 dollars [1]	$1,842	$2,128	$2,077	$2,061	$2,085	$2,303	$2,598	$2,843	$3,338	$3,917	$4,431	$5,059	$5,267
Total AFDC collections [2]	$472	$597	$603	$671	$786	$880	$1,000	$1,092	$1,225	$1,349	$1,484	$1,593	$1,754
Federal	$311	$244	$246	$266	$311	$349	$402	$341	$369	$413	$443	$458	$535
State	$148	$274	$274	$302	$354	$396	$448	$415	$424	$473	$525	$563	$622
Total non-AFDC collections	$575	$736	$874	$958	$984	$1,144	$1,378	$1,604	$2,019	$2,569	$3,130	$3,667	$4,281
Total administrative expenditures	$312	$383	$466	$526	$612	$691	$723	$814	$941	$1,066	$1,171	$1,363	$1,606
Federal	$236	$287	$349	$394	$459	$487	$507	$571	$633	$750	$804	$938	$1,061
State	$76	$96	$117	$132	$153	$204	$216	$243	$308	$316	$366	$426	$545
Federal incentive payments to States and localities	$54	$66	$72	$90	$107	$121	$134	$145	$158	$185	$222	$266	$264
Average number of AFDC cases in which a collection was made	458	463	503	548	597	595	647	684	582	609	621	657	700
Average number of non-AFDC cases in which a collection was made	249	224	243	325	448	507	547	654	786	934	1,083	1,247	1,362
Number of families removed from AFDC due to child support collections	19	27	40	46	32	26	41	34	[4] 287	192	198	220	239

Number of parents located	454	574	643	696	779	831	875	878	1,046	1,145	1,388	1,624	2,057
Number of paternities established	111	138	144	164	173	208	219	232	245	269	307	337	391
Number of support obligations established	315	349	374	414	462	496	573	669	731	812	871	936	1,018
Percent of AFDC assistance payments recovered through child support collections	([3])	5.6	5.2	5.2	6.8	6.6	7.0	7.3	8.6	9.1	9.8	10.1	10.3
Total child support collections per dollar of total administrative expenses	$3.35	$3.48	$3.17	$3.09	$2.89	$2.93	$3.29	$3.31	$3.45	$3.68	$3.94	$3.85	$3.76

---

[1] Adjusted for inflation using CPI. [2] AFDC collections are divided into State/Federal shares and incentives are taken from the Federal share thereby reducing the Federal amounts.
[3] Not available. [4] Definition changed to all cases closed where a child support payment was received.

Source: Office of Child Support Enforcement.

TABLE 2.—COMPARISON OF MEASURES OF IV–D EFFECTIVENESS WITH CENSUS CHILD SUPPORT DATA, 1978–87

Measure	Year				Percent change, 1978–87
	1978	1983	1985	1987	
From Child Support Program Statistics:					
Total collections (1987 dollars in billions)[1]	$1.8	$2.3	$2.8	$3.9	117
Parents located (thousands)	454	831	878	1,145	152
Paternities established (thousands)	111	208	232	269	142
Awards established (thousands)	315	496	669	812	158
From Census Surveys:					
Total collections (1987 dollars in billions)[1]	$8.2	$8.1	$7.6	$10.0	22
IV–D collections as percent of total collections	23	28	37	39	70
Of demographically eligible, percent with awards	59	58	61	59	0
Of demographically eligible, percent supposed to receive payment	48	46	50	51	6
Of demographically eligible, percent who received some payment	35	35	37	39	11
Of mothers supposed to receive payment, percent who received full amount	49	50	48	51	4
Percent of poor female-headed families with child support or alimony	[2] 18.6	NA	NA	26.0	[3] 40
Child support dual alimony as a percent of total income received by poor female-headed families	[2] 4.7	NA	NA	5.5	[3] 17
Percent of female-headed families with child support or alimony	[2] 33.9	NA	NA	35.8	[3] 6
Child support and alimony as a percent of total income received by female-headed families	[2] 7.4	NA	NA	6.8	[3] −8

[1] Constant (1987) dollars using CPI.

[2] 1979 data.

[3] Percentage change 1979 to 1987.

NA—Not available.

Note.—Demographically eligible means women with own children under 21 years of age living with them from an absent father.

Sources: U.S. Bureau of the Census, Child Support and Alimony, Current Population Reports, Series P–23, 1978, No. 112; 1983, No. 141; 1985, No. 152.

In 1989, 43 percent of the 7.4 million families maintained solely by the mother with children under 18, had incomes below the poverty threshold. Almost 10 percent of the mothers of these poor children worked full-time, full-year.

In 1989, 15.5 million children (under 18) lived with only one parent, 89 percent more than in 1970. Even though the total number of children under 18 years old in the United States declined from 69 million in 1970 to 63.6 million in 1989, the number of children affected by divorce, separation, and unmarried status of mother continued to rise. Twenty-four percent of all children lived in a one-parent family in 1989, compared with 12 percent in 1970. A 1985 current population survey indicated that about 15 percent of children living in two-parent married-coupled families were living with a step-parent.

Of the 15.5 million children living with one parent, 88 percent lived with their mothers and nearly 12 percent with their fathers. Between 1970 and 1989 the number of children living with only their fathers grew by 140 percent (from 748,000 to 1,793,000). The proportion of all children who lived with only their fathers rose from 1.1 percent to 2.8 percent.

The largest number of children in one-parent families had a parent who was divorced, followed by children whose parents were never married or separated. In 1989, of the children who lived only with one parent, 39 percent had a parent who was divorced, 24 percent had a parent who was separated, and 31 percent had a parent who had never been married. The number of children with a divorced parent has more than doubled since 1970, but the number with a never-married parent grew by a multiple of 8.

THE PROCESS OF CHILD SUPPORT ENFORCEMENT

Local family and domestic courts and administrative agencies handle child support enforcement problems according to Federal, State, and local laws. Working with the parents and considering the best interests of the children, the courts decide which parent will have custody of the children, the amount of the child support obligation of the noncustodial parent, the rights of access to the children by the noncustodial parent, and how the support obligation will be enforced.

The child support enforcement program provides services aimed at locating absent parents, establishing paternity, establishing a support obligation, and enforcing the support obligation. The child support enforcement program does not provide services aimed at other issues between parents, such as property settlement, custody, and access to the children. These issues are handled by local courts with the help of private attorneys.

Any parent who needs help in locating an absent parent, establishing paternity, establishing a support obligation, or enforcing a support obligation may apply for services. Parents receiving benefits under the Aid to Families with Dependent Children (AFDC) program, the federally assisted foster care program or the Medicaid program automatically receive services. Services are free to such recipients, but others are charged up to $25 for services. States can charge fees on a sliding scale, pay the fee out of State funds or recover the fees from the noncustodial parent.

When a parent applies for child support enforcement services, the following information aids the process: the name and address of the noncustodial parent; the absent parent's Social Security number; children's birth certificates; the child support order; the divorce decree or separation agreement; the name and address of the most recent employer of the noncustodial parent; the names of friends and relatives or organizations to which the noncustodial parent might belong; information about income and assets; and any other information about absent parents that might help the locating process. Once this information is provided, it is used in strictest confidence.

If the child support enforcement program cannot locate the noncustodial parent with the information provided by the custodial parent, it must try to locate the noncustodial parent through the State parent locator service. The State uses various information such as telephone directories, motor vehicle registries, tax files, and employment data. The State also can ask the Federal Parent Locator Service (FPLS) to locate the noncustodial parent. The FPLS can access data from the Social Security Administration, the Internal Revenue Service, the Selective Service System, the Department of Defense, the Veterans' Administration, and the National Personnel Records Center.

Under the Family Support Act of 1988 (P.L. 100-485), States are required to initiate the establishment of paternity for all children under the age of 18, including those for whom an action to establish paternity was previously dismissed because of the existence of a statute of limitations of less than 18 years. The act also sets paternity establishment standards for the States, and encourages them to create simple civil procedures for establishing paternity in contested cases. All parties to a contested case may be required to submit to genetic testing. The Federal Government pays 90 percent of the laboratory costs, and States may charge persons not receiving AFDC for the cost of establishing paternity.

Under the Family Support Act of 1988, a State must use its child support award guidelines in establishing the child support obligation of the noncustodial parent. Also, the State must review and adjust individual awards every 3 years under certain circumstances beginning October 13, 1993.

Local courts and child support enforcement agencies attempt to collect child support when the noncustodial parent does not pay. If the arrearage sums to 30 days or more worth of support, the State must impose wage withholding on the noncustodial parent. The Family Support Act expands this authority so that wage withholding will eventually apply to nearly all cases. Other techniques for enforcing support include regular billings, delinquency notices, liens on property, seizure and sale of property, reporting arrearages to credit agencies, garnishment of wages, and offsetting of State and Federal income taxes.

States might bring charges of criminal nonsupport against noncustodial parents if they cannot collect, or they might use civil or criminal contempt-of-court charges. These court proceedings usually involve much time because of court backlogs, delays, and continuances. Once a court decides the case, noncustodial parents often have been given probation or suspended sentences, and lower support payments and only partial payment of arrearages. To combat problems associated with court delays, the statute requires States to implement expedited processes under the State judicial system or State administrative processes for obtaining and enforcing support orders and at State option for establishing paternity.

The most difficult child support orders to enforce are the interstate cases. States are required to cooperate in interstate child support enforcement, but problems arise from the additional autonomy of the local courts. Family law has been under the jurisdiction of State and local governments, and citizens fall under the jurisdiction of the courts where they live.

If the noncustodial parent lives out of State, the primary tool for interstate enforcement is the Uniform Reciprocal Enforcement of Support Act (URESA). All States have their own URESA laws. Under these laws, the child support enforcement official or private attorney files a two-State petition with the enforcement agency or a court in another State. Where the URESA provisions in the two States are compatible, the law can be used effectively. However, many of these laws are out of date and incompatible, which makes interstate child support enforcement relatively ineffective.

The National Conference of Commissioners on Uniform State Laws originally drafted a model URESA in 1950. Since then, amendments have been made in 1952, 1958, and 1968. The Family Support Act of 1988 authorizes a commission to study problems in interstate child support enforcement. It is required to report to Congress by May 1, 1991.

Child support awards

In 1987, of the 9.4 million women who had children present under the age of 21 from an absent father, 41 percent never were awarded child support rights (nor had an agreement to receive child support payments) and, thus, were dependent for income on sources other than the father. For poor mothers, the proportion without child support awards was even higher at 56 percent (see table 4).

Approximately 5.6 million women with children under age 21 (59 percent) had been awarded child support or had an agreement to receive child support payments, but only 4.8 million (51 percent) of the women were actually "supposed to receive" child support in 1987. The rights of the remaining 8 percent were no longer in force because the father who owed payments had died, the children had grown past the age of eligibility for payments, or because of another such reason.

Many of the women who were awarded child support payments did not receive the full amount they were due. In 1987, about half (51 percent) of the 4.8 million women owed child support payments received the full amount, about 25 percent of the women received less than they were owed, and 24 percent received no payment at all. Table 4 shows that average amount of child support for women who *received* payments in 1987 was $2,710, about 19 percent of their average total income. In 1978, the average amount of child support was $1,800, about 20 percent of the woman's income.

TABLE 3.—CHILD SUPPORT AND ALIMONY PAYMENTS IN 1978, 1983, 1985, AND 1987

[Women as of spring 1979, 1984, 1986, and 1988. Child support payments for women with own children under 21 years of age present from an absent father: alimony payment for ever-divorced women]

Year, award and recipiency status of women	1978		1983		1985		1987	
	Number (thousands)	Percent distribution	Number (thousands)	Percent distribution	Number (thousands)	Percent distribution	Number (thousands)	Percent distribution
Child Support Payments								
Total	7,094	100.0	8,690	100.0	8,808	100.0	9,415	100.0
Awarded [1]	4,196	59.1	5,015	57.7	5,396	61.3	5,554	59.0
Supposed to receive payments	3,424	48.3	3,995	46.0	4,381	49.7	4,829	51.3
Not supposed to receive payments	772	10.9	1,020	11.7	1,015	11.5	725	7.7
Not awarded [1]	2,898	40.9	3,675	42.3	3,411	38.7	3,861	41.0
Supposed to receive payments	3,424	100.0	3,995	100.0	4,381	100.0	4,829	100.0
Actually received payments	2,455	71.6	3,037	76.0	3,243	74.0	3,676	76.1
Received full amount	1,675	48.9	2,018	50.5	2,112	48.2	2,475	51.3
Received partial amount	779	22.8	1,019	25.5	1,131	25.8	1,201	24.9
Did not receive payments	969	28.4	958	24.0	1,138	26.0	1,153	23.9
Alimony								
Total	14,334	100.0	17,392	100.0	19,156	100.0	19,271	100.0
Awarded [1]	2,052	14.3	2,416	13.9	2,803	14.6	3,243	16.8
Supposed to receive payments	760	5.3	791	4.5	840	4.4	1,186	6.2
Not supposed to receive payments	1,292	9.0	1,625	9.3	1,963	10.2	2,057	10.7
Not awarded [1]	12,282	85.7	14,976	86.1	16,354	85.4	16,028	83.2
Supposed to receive payments	760	100.0	791	100.0	840	100.0	NA	NA
Actually received payments	528	69.5	608	76.9	616	73.3	NA	NA
Received full amount	312	41.1	NA	NA	NA	NA	NA	NA
Received partial amount	216	28.4	NA	NA	NA	NA	NA	NA
Did not receive payments	232	30.5	183	23.1	225	26.8	NA	NA

[1] Award status as of spring 1979, 1984, 1986, and 1988.

Source: U.S. Bureau of the Census. Current Population Reports, Series P–23, No. 112 Child Support and Alimony 1978, No. 141 Child Support and Alimony 1983 (advance report), No. 152 Child Support and Alimony 1985 (advance report) and No. 167 Child Support and Alimony: 1987. Washington U.S. Government Printing Office.

TABLE 4.—CHILD SUPPORT PAYMENTS AWARDED AND RECEIVED IN 1987—WOMEN WITH CHILDREN PRESENT, BY SELECTED CHARACTERISTICS

[Women with own children under 21 years of age present from an absent father as of spring 1988]

Characteristics of women	Total (thousands)	Percent awarded child support payments [1]	Supposed to receive child support in 1987			
			Total (thousands)	Actually received support in 1987		
				Percent	Mean child support	Mean income
All women:						
Total	9,415	59.0	4,829	76.1	$2,710	$14,245
Current Marital Status						
Married [2]	2,386	82.0	1,656	72.9	2,540	12,582
Divorced	2,958	77.2	2,087	78.0	3,073	17,487
Separated	1,381	54.8	628	74.0	2,745	12,777
Widowed [3]	64	(B)	27	(B)	(B)	(B)
Never married	2,625	19.7	430	83.3	1,632	7,203
Race and Spanish Origin						
White	6,467	68.8	3,910	76.6	2,950	14,988
Black	2,686	35.6	787	73.2	1,503	10,257
Spanish origin [4]	937	42.4	344	75.6	2,628	9,184
Years of School Completed						
Less than 12 years	2,349	42.9	855	69.7	1,872	6,472
High school: 4 years	4,486	59.4	2,285	75.6	2,518	12,205
College:						
1 to 3 years	1,739	71.0	1,105	77.5	2,750	16,699
4 years or more	842	77.0	584	85.1	4,310	26,430
Women below poverty:						
Total	3,191	44.3	1,231	71.9	1,673	4,566
Current Marital Status						
Married [2]	167	78.4	108	70.4	1,646	2,520
Divorced	791	74.2	538	68.4	1,799	5,272
Separated	710	50.8	300	68.3	2,222	4,181
Widowed	25	(B)	11	(B)	(B)	(B)
Never Married [3]	1,498	21.3	274	83.9	1,018	4,468
Race						
White	1,659	53.0	772	71.1	1,962	4,758
Black	1,431	34.2	417	72.9	1,187	4,276
Spanish origin [4]	473	38.1	150	79.3	2,850	4,629

[1] Award status as of spring 1986.

[2] Remarried women whose previous marriage ended in divorce.

[3] Widowed women whose previous marriage ended in divorce.

[4] Persons of Spanish origin may be of any race.

Note.—B base less than 75,000.

Source: U.S. Bureau of the Census. Series P–23, No. 167, Child Support and Alimony: 1987.

Of the 9.4 million women with children by an absent father, about 3.2 million (34 percent) had incomes below the poverty level. Of these women, only 39 percent (1,231,000) had agreements to receive child support and were due payments in 1987. Another 6 percent had agreements but were not due payments in 1987 (see table 4).

Of the poor mothers who were supposed to receive child support payments in 1987, 71.9 percent (885,089) actually received payments, while 28.1 percent did not.

For women who actually received child support payments in 1987, the amount of payment tended to be higher than average for divorced women, white women, women over age 30, and women who had gone to college for at least a year. Those with lower than average payment amounts included never-married women, black women, women of Spanish origin, and women who had not completed 12 years of school (see table 4).

Only 20 percent of women who had never married were awarded child support payments; compared with 77 percent of divorced women, 82 percent of remarried women and 55 percent of women who were separated. Moreover, among the 4.8 million women who were supposed to receive child support, the percentages of those who actually received payments were: 83 percent of never-married mothers, 73 percent of remarried mothers, 74 percent of separated mothers, and 78 percent of divorced mothers.

Of the 3.7 million women who actually received child support payments in 1987, 44 percent were divorced, 33 percent were remarried, 13 percent were separated, and 10 percent were single (never married). The women who had never married received, on the average, the lowest amount of child support payments. Among women who were poor despite having been awarded child support, the percentages differed. Of the 885,089 poor women who received child support payments in 1987, 42 percent were divorced, 9 percent were remarried, 23 percent were separated, and 26 percent were never married.

Black mothers and mothers of Spanish origin living apart from the father of their children were much less likely than their white counterparts to be awarded child support. Almost 69 percent of white mothers were awarded child support payments, compared with 36 percent of black mothers, and 42 percent of mothers of Spanish origin. Further, both black and Spanish-origin mothers received smaller payments, on the average, than did white mothers.

Mothers who were not high school graduates were less likely than the average to be awarded child support, and their support payments were on the average much smaller than those of mothers who had completed more than 12 years of school.

In addition, the age of the woman was related to the awarding of child support payments. Women aged 40 and over were the most likely to be awarded child support. Women 40 years of age and older were also the most likely to actually receive payments and they received, on average, higher support payments. Women under age 30 were the least likely to be awarded payments, and those who were awarded support received smaller payments, on average, than older women.

Another factor related to child support was the number of children the mother had with her in the absence of their father. Women with three children were the most likely to receive support.

SERVICES FOR AFDC AND NON-AFDC CASES

Each State's child support plan must provide that the child support agency will undertake to secure support for an AFDC child whose rights to support have been assigned to the State. This includes nearly all AFDC children, since assignment of rights to support is a condition of eligibility for AFDC benefits. The State must also provide in its plan that it will undertake to establish the paternity of an AFDC child who is born out of wedlock. These requirements apply in all cases except where, in accordance with standards established by the Secretary, the State finds that to apply them would be against the best interests of the child. For families whose AFDC eligibility ends due to the receipt of (or an increase in) child support, States must continue to provide child support enforcement services, without imposing the application fee. This policy was established by Public Law 98-378.

With respect to non-AFDC families, the law provides that the State must make available, once an application is filed with the State agency, the child support collection and paternity determination services which are provided under the plan for AFDC families. The State must charge non-AFDC families an application fee of up to $25. The amount of the maximum allowable fee may be adjusted periodically by the Secretary of the Department of Health and Human Services to reflect changes in administrative costs. States may charge the fee against the custodial parent, pay the fee out of State funds, or recover it from the noncustodial parent.

States also have the option of charging a late payment fee equal to between 3 and 6 percent of the amount of overdue support. Late payment fees may be charged to the noncustodial parents of AFDC and non-AFDC families and are to be collected only after the full amount of the support has been paid to the child. In addition, a State may at its option recover costs in excess of the application fee. Such recovery may be from either the custodial parent or the noncustodial parent. If a State chooses to make recovery from the custodial parent, it must have in effect a procedure whereby all persons in the State who have authority to order support are informed that such costs are to be collected from the custodial parent.

Finally, child support enforcement services must include the enforcement of spousal support, but only if a support obligation has been established with respect to the spouse, the child and spouse are living in the same household, and child support is being collected along with spousal support.

THE FEDERAL ROLE

The Federal statute provides that the child support program must be administered by a separate organizational unit under the control of a person designated by and reporting directly to the Secretary of Health and Human Services (HHS). Under the present organizational structure of the Department, this office is known as the Federal Office of Child Support Enforcement (OCSE). The Family Support Act of 1988 requires the appointment of an Assistant Secretary for Family Support within HHS to administer a number of programs, including the Child Support Enforcement program under title IV-D of the act.

A primary responsibility of the director is to establish such standards for State programs for locating absent parents, establishing paternity, and obtaining child support and support for the spouse (or former spouse) with whom the absent parent's child is living as he determines to be necessary to assure that the programs will be effective. In addition to this broad statutory mandate, the director is required to establish minimum organizational and staffing requirements for State child support agencies, and to review and approve State plans.

The statute also requires the director of the OCSE to provide technical assistance to the States to help them establish effective systems for collecting child and spousal support and establishing paternity. To fulfill this requirement, the OCSE has established a National Child Support Enforcement Reference Center as a central location for the collection and dissemination of information about State and local programs. It operates, under a contract, the National Institute for Child Support Enforcement, to provide training and technical assistance to persons working in the field of child support enforcement. Special initiatives, such as a recent effort to assist major urban areas in improving program performance, have also been undertaken by the OCSE.

The Child Support Enforcement Amendments of 1984 (Public Law 98-378) extend the research and demonstration authority in section 1115 of the Social Security Act to the child support enforcement program. This will make it possible for States to test innovative approaches to support enforcement so long as the modification would not disadvantage children in need of support nor result in an increase in Federal AFDC costs. Public Law 98-378 also authorizes special project grants to promote improvement in interstate enforcement. The authorization is $15 million for each fiscal year after 1986.

The director of the OCSE has full responsibility for program evaluation. Prior to fiscal year 1984 the statute required him to conduct an annual audit of each State's program to determine whether the actual operation of the program conformed to Federal requirements. The penalty for noncompliance was a reduction of 5 percent in the Federal matching that would otherwise be payable to the State under the Aid to Families With Dependent Children (AFDC) program. This penalty was never imposed; legislation was periodically enacted to suspend its implementation.

Public Law 98-378 modified these audit and penalty requirements. Audits are now required at least every 3 years to determine whether the standards and requirements prescribed by law and regulations have been met. Under the penalty provision, a State's AFDC matching funds must be reduced by an amount equal to at least 1 but no more than 2 percent for the first failure to comply substantially with the standards and requirements, at least 2 but no more than 3 percent for the second failure, and at least 3 but no more than 5 percent for the third and subsequent failures.

FEDERAL ENFORCEMENT TOOLS

The statute creates several Federal mechanisms to assist the States in performing their paternity and child support enforcement functions. These include use of the Internal Revenue Service, the Federal courts, and the Federal Parent Locator Service (FPLS).

The statute requires the Secretary of HHS, upon the request of a State, to certify to the Secretary of Treasury for collection by the IRS any amounts identified by the State as representing delinquent child support payments. The Secretary may certify only the amounts delinquent under a court or administrative order, and only upon a showing by the State that it has made diligent and reasonable efforts to collect amounts due using its own collection mechanisms. States must reimburse the Federal Government for any costs involved in making the collections. Collections may be made on behalf of both AFDC and non-AFDC families. Use by the States of this regular IRS collection mechanism (which may include seizure by the IRS of property, freezing of accounts, and other procedures) has been relatively infrequent. In fiscal year 1989, collections were made in only 308 cases nationwide, for a total collection of $255,807.

The availability of the IRS collection mechanism for child support was amplified in amendments enacted as part of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) to allow the collection of past due support from Federal tax refunds upon a simple showing by the State agency that an individual owes at least $150 in past-due support which has been assigned to the State as a condition of AFDC eligibility. Upon receiving this showing, the Secretary of Treasury is required to withhold from any tax refunds due that individual an amount equal to any past-due support. The withheld amount is sent to the State agency, together with notice of the taxpayer's current address.

Public Law 98–378 created a similar IRS offset program for non-AFDC families owed child support. States must submit to the IRS for withholding, the names of absent parents who have arrearages of at least $500 and who, on the basis of current payment patterns and the enforcement efforts that have been made, are unlikely to pay the arrearage before the IRS offset can occur. The law establishes specific notice requirements and mandates that the absent parent and any spouse be informed of the procedures which may be taken to protect the unobligated spouse's portion of the refund. The 1988 provision applied to refunds payable after December 31, 1985, and before January 1, 1991. Public Law 101–508 makes permanent the IRS offset program for non-AFDC families.

In 1989, a total of 760,218 cases were offset, which resulted in child support collections of $444 million.

States also may have access to the Federal courts to enforce court orders for support. The director of the Office of Child Support Enforcement must approve a State's application for permission to use the courts of the United States to enforce court orders for support upon a finding that: (1) another State has not undertaken to enforce the court order of the originating State against an absent parent within a reasonable time; and (2) that use of the Federal courts is the only reasonable method of enforcing such order. This mechanism, designed to assist the States in enforcing interstate cases, has gone unused, apparently because the States view it as costly and complex.

Finally, the statute also requires the establishment of a Federal Parent Locator Service to be used to find absent parents in order to enforce child support obligations. Upon request, the Secretary of HHS must provide to an authorized person the most recent address and place of employment of any absent parent if the information is contained in the records of the Department of Health and Human Services, or can be obtained from any other department or agency of the United States or of any State. The Secretary must also make available the services of the PLS to any State that wishes to locate an absent parent or child for the purpose of enforcing any Federal or State law with respect to the unlawful taking or restraint of a child, or making or enforcing a child custody determination.

THE STATE ROLE

Each State is required to designate a single and separate organizational unit of State government to administer the program. Earlier child support legislation, enacted in 1967, had required that the program be administered by the welfare agency. The 1975 act deleted this requirement in order to give each State the opportunity to select the most effective administrative mechanism. Most States have placed the child support agency within the social or human services umbrella agency which also administers the AFDC program. However, two States have placed the agency in the department of revenue. The law allows the programs to be administered either on the State or local level. Ten programs are locally administered. A few programs are State administered in some counties and locally administered in others.

States must have plans, approved by the director of the OCSE, which set forth their functions and responsibilities. Both AFDC and non-AFDC families must be served. States must also enter into cooperative arrangements with appropriate courts and law enforcement officials to assist the child support agency in administering the program. These agreements may include provision for reimbursing courts and law enforcement officials for their assistance. States must operate a parent locator service to locate absent parents, and they must maintain full records of collections and disbursements, and otherwise maintain an adequate reporting system.

In order to facilitate the collection of support in interstate cases, a State must cooperate with other States in establishing paternity, locating absent parents, and in securing compliance with an order issued by another State.

The law requires the States to use several enforcement tools. They must use the IRS tax refund offset procedure for AFDC and non-AFDC families, and they must also determine periodically whether any individuals receiving unemployment compensation owe child support obligations. The State employment security agency is required to withhold unemployment benefits, and to pay the child support agency any outstanding child support obligations established by an agreement with the individual or through legal processes.

Public Law 98-378 mandated that States use a number of other enforcement techniques, beginning on October 1, 1985. These include: (1) mandatory wage withholding if support payments are delinquent in an amount equal to one month's support; (2) imposing liens against real and personal property for amounts of overdue support; (3) withholding of State tax refunds payable to a parent who is delinquent in support payments; (4) making available information regarding the amount of overdue support owed to a consumer credit bureau upon a request; (5) requiring individuals who have demonstrated a pattern of delinquent payments to post a bond or give some other guarantee to secure payment of overdue support; (6) establishing expedited processes within the State judicial system or under administrative processes for obtaining and enforcing child support orders, and, at the option of the State, determining paternity; (7) notifying each AFDC recipient at least once each year of the amount of child support collected on behalf of that recipient; (8) permitting the establishment of paternity until a child's 18th birthday; and (9) at the option of the State, providing for cases not enforced by the State CSE agency, that child support payments must be made through the agency that administers the State's income withholding system if either the custodial or noncustodial parent requests that they be made in this manner.

State child support agencies are required to undertake child support collections on behalf of children receiving foster care maintenance payments under title IV-E of the Social Security Act, if an assignment of rights to support has been secured by the foster care agency. In addition, foster care agencies are required to take steps, where appropriate, to secure an assignment to the State of any rights to support on behalf of a child receiving foster care maintenance payments.

State agencies are also required, as a result of Public Law 98-378, to petition to include medical support as part of any child support order whenever health care coverage is available to the noncustodial parent at a reasonable cost. And, if a family loses AFDC eligibility as the result of increased collection of support payments, the State must continue to provide Medicaid benefits for 4 calendar months beginning with the month of ineligibility. States also must provide services to medically needy (Medicaid only) families referred to the State IV-D agency from the State Medicaid agency.

Finally, the statute requires each State to comply with any other requirements and standards that the Secretary determines to be necessary to the establishment of an effective child support program.

ENFORCEMENT OF MEDICAL SUPPORT

Health care for children can be a major expense for the custodial parent, and can be a burden for the State if public assistance is being provided to the children. Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Section 1912 of the Social Security Act), permits State Medicaid agencies to use the CSE agency to assist in the enforcement of medical support rights due from or through a noncustodial parent, since it was not intended that the Medicaid agency establish a separate system for the enforcement of medical support obligations. On February 11, 1980, the OCSE and the Health Care Financing Administration (HCFA) published joint regulations to implement section 1912 of the act through optional cooperative agreements between the State Medicaid agency and the State CSE agency. Under these agreements the Medicaid agency reimburses the CSE agency for medical support enforcement activities performed pursuant to the agreement. In 33 States the Federal Medicaid reimbursement rate is lower than the 66 percent matching rate for CSE activities (applicable to fiscal year 1990 and years thereafter), and nationwide it averages about 56 percent.

Section 16 of Public Law 98-378 requires the Secretary of the Department of Health and Human Services (DHHS) to issue regulations to require that State CSE agencies petition for the inclusion of medical support as part of any child support order whenever health care coverage is available to the noncustodial parent at reasonable cost. According to the Federal regulations, any employment-related or other group coverage is considered reasonable, under the assumption that health insurance is inexpensive to the employee/noncustodial parent. A 1983 study by the National Center for Health Services Research of the Public Health Service indicated that, for low-wage employees with employer-provided insurance coverage, 72 percent of the premium was paid for by the employer.

On October 16, 1985, the OCSE published regulations amending previous regulations and implementing section 16 of Public Law 98-378. The regulations stated that the CSE agency must obtain basic medical support information and provide this information to the State Medicaid agency. Also, if the custodial parent does not have satisfactory health insurance coverage, the CSE agency must petition the court or administrative authority to include medical support in new or modified support orders and inform the State Medicaid agency of any new or modified support orders that include a medical support obligation. The 1985 regulations also required the CSE agency to take steps to enforce medical support that has been ordered by a court or administrative process under State law. In addition, these regulations permit the use of CSE matching funds at the 66 percent rate for required medical support activities. Before these regulations were issued, medical support activities were pursued by CSE agencies only under optional cooperative agreements with Medicaid agencies. Some of the functions that the CSE agency may perform under a cooperative agreement with the Medicaid agency include: receiving referrals from the Medicaid agency, locating absent parents, establishing paternity, determining whether the noncustodial parent has a health insurance policy or plan that covers the child, obtaining sufficient information about the health insurance policy or plan to permit the filing of a claim with the insurer, filing a claim with the insurer or transmitting the necessary information to the Medicaid agency, securing health insurance coverage through court or administrative order (when it will not reduce the noncustodial parent's ability to pay child support), and recovering amounts necessary to reimburse medical assistance payments.

A report by the Urban Institute stated that although the practice of including medical coverage provisions in child support orders had increased, the priority and emphasis given such provision was still quite low (as of September 1985). It reported that child support staff were reluctant to go to court just for medical support, and that many judges would not order medical support if it might cause a reduction in cash support payments. The report also said that enforcing medical coverage provisions once they are established is very difficult, and that it requires the agency to monitor continuation of coverage and to act to restore coverage when it lapses.[1]

The Urban Institute study reported that in 1983, 4.6 million children with an absent parent were without public (Medicaid) or private health insurance. This represented 34 percent of all children with an absent parent. Another 4.9 million children with an absent parent were covered solely by Medicaid. The study estimated that including medical coverage in child support orders in 1984 might have benefited 1,353,000 totally uninsured children (those without Medicaid or private insurance) and perhaps another 300,000 to 466,000 children covered only by Medicaid at that time.[2]

According to the Census Bureau data on child support and alimony, 45 percent of the 5.4 million women who were awarded child support in 1985 received health insurance coverage in their awards. For white women, the figure was 48 percent; for black women, 26 percent; and for women of Hispanic origin, 25 percent. For divorced women, the figure was 50 percent and for women who had never married, the figure was 24 percent.

On September 16, 1988, the OCSE issued regulations amending the medical support enforcement provisions. These regulations require the CSE agency to develop criteria to identify existing child support cases that have a high potential for obtaining medical support, and to petition the court or administrative authority to modify support orders to include medical support for targeted cases even if no other modification is anticipated. In addition, the CSE agency is required to provide the custodial parent with information regarding the health insurance coverage obtained by the noncustodial parent for the dependent child or children. Moreover, the 1988 regulation deletes the condition that CSE agencies may secure health insurance coverage under a cooperative agreement only when it will not reduce the noncustodial parent's ability to pay child support. The purpose of the medical support provisions is to expand the number of children for whom private health insurance coverage is obtained by increasing the availability of third-party resources to pay for medical care and thereby result in Medicaid cost savings to the States and the Federal Government. The Urban Institute report, however, concluded that while there is no doubt that many children could benefit from inclusion of medical insurance, especially those who currently have no public or private health care coverage, Medicaid savings would be relatively modest compared to total annual Medicaid costs.[3]

---

[1] Nightingale, Demetra Smith, and others. "The Inclusion of Medical Coverage in Child Support Cases: Current Status and Options for the Future." Draft. Washington, Urban Institute, May 1986. p. vi. [Hereafter cited as Urban Institute, "The Inclusion of Medical Coverage in Child Support Cases"]

[2] Ibid., p. 24–25.

TABLE 5.—CHILD SUPPORT AWARD STATUS AND INCLUSION OF HEALTH INSURANCE IN AWARD, BY SELECTED CHARACTERISTICS OF WOMEN

[Women with own children under 21 years of age present from absent fathers as of spring 1986]

Characteristic	Total (thousands)	Awarded child support payments		
		Total (thousands)	Health insurance included in child support award	
			Number (thousands)	Percent of total awarded
Total	8,808	5,396	2,402	44.5
Current Marital Status [1]				
Married [2]	2,322	1,904	818	43.0
Divorced	3,045	2,492	1,255	50.4
Separated	1,363	587	224	38.2
Never married	2,009	370	90	24.3
Race and Hispanic Origin				
White	6,341	4,476	2,167	48.4
Black	2,310	839	214	25.5
Hispanic [3]	813	342	86	25.1
Age				
18 to 29 years	2,887	1,288	501	38.9
30 to 39 years	3,614	2,547	1,142	44.8
40 years and over	2,307	1,561	758	48.6
Years of School Completed				
Less than 12 years	2,230	1,009	343	34.0
High school: 4 years	4,176	2,645	1,207	45.6
College:				
1 to 3 years	1,653	1,169	539	46.1
4 years or more	748	573	312	54.5
Number of Own Children Present from an Absent Father				
One child	4,607	2,783	1,161	41.7
Two children	2,879	1,953	935	47.9
Three children	867	502	224	44.6
Four children or more	456	159	81	50.9

[1] Excludes a small number of current widowed women whose previous marriage ended in divorce.

[2] Remarried women whose previous marriage ended in divorce.

[3] Persons of Hispanic origin may be of any race.

Source: U.S. Bureau of the Census. Current Population Reports. Child Support and Alimony: 1985 (Supplemental Report). Series P–23, No. 154, March 1989. Washington, U.S. Government Printing Office, 1989. p. 9.

---

[3] Urban Institute, "The Inclusion of Medical Coverage in Child Support Cases," p. vi.

WAGE WITHHOLDING

Public Law 98-378 requires that States have in effect two distinct procedures for withholding wages of noncustodial parents. First, for cases enforced through the CSE agency, States must have and use a procedure that requires wage withholding to be triggered in child support cases whenever an arrearage accrues that is equal to the amount of support payable for 1 month. Second, for all child support cases, all new or modified support orders issued in the State must include a provision for wage withholding when an arrearage occurs. The intent of the second procedure is to ensure that orders not enforced through the CSE agency contain the authority necessary to permit wage withholding to be initiated by someone other than the CSE agency. (Note: as described later, P.L. 100-485 extends the use of mandatory wage withholding to nondelinquent support.)

In fiscal year 1989, 42 percent of non-AFDC collections and 39 percent of AFDC collections were made through wage withholding.

According to the Federal statute, State due-process requirements govern the scope of notice to provide to an obligor (i.e., noncustodial parent) when withholding is triggered. As a general rule, the noncustodial parent is entitled to advance notice of the alleged delinquency and the withholding procedure. This notice, where required, must inform the noncustodial parent of the following: the amount of overdue support owed; the amount that will be withheld; the application of withholding to any current or subsequent period of employment; the procedures available for contesting the withholding and the sole basis for objection (i.e., mistake of fact); the period allotted the noncustodial parent to contact the State to contest the withholding and the result of failure to contact the State within this timeframe (i.e., issuance of notification to the employer to begin withholding); the steps the State will take if the noncustodial parent contests the withholding including the procedure to resolve such contests.

If the noncustodial parent contests the income withholding notice, the State must conduct a hearing, determine if the withholding is valid, notify the noncustodial parent of the decision, and notify the employer to commence the deductions if withholding is upheld. All of this must occur within 45 days of the initial notice of withholding. Whether a State uses a judicial or an administrative process, the only basis for a hearing is a factual mistake about the amount owed (current and/or arrearage) or the identity of the noncustodial parent.

When withholding is uncontested or when a contested case is resolved in favor of the withholding, the administering agency must serve a withholding notice on the employer. The employer is required to withhold as much of the noncustodial parent's wages as is necessary tc comply with the order. This will include the current support amount plus an amount to be applied toward liquidation of any arrearage. In addition, the employer may retain a fee to offset the administrative cost of implementing withholding.

The Federal Consumer Credit Protection Act (FCCPA) determines the maximum portion of an individual's total disposable earnings that is subject to garnishment. The FCCPA limits apply when enforcing an order for support. These limits are 50 percent of disposable earnings for a noncustodial parent who is the head of a household, and 60 percent for a noncustodial parent who is supporting a second family. These percentages increase by 5 percentage points, to 55 and 65 percent, respectively, when the arrearages represent support that was due more than 12 weeks before the current pay period.

Upon receiving the notice, the employer must begin withholding the appropriate amount of the obligor's wages no later than the first pay period that occurs after 14 days following the date the notice was mailed. The 1984 amendments regulate the language in State statutes on the other rights and liabilities of the employer. For instance, the employer is subject to a fine for discharging a noncustodial parent or taking other forms of retaliation as a result of a withholding order. In addition, the employer is held liable for amounts not withheld as directed.

In addition to being able to charge the noncustodial parent a fee for the administrative costs associated with wage withholding, the employer can combine all support payments required to be withheld for multiple obligors into a single payment and forward it to the CSE agency or court with a list of the cases to which the payments apply. The employer need not vary from his normal pay and disbursement cycle to comply with withholding orders; however, support payments must be forwarded to the State or other designated agency within 10 days of the date on which the noncustodial parent is paid.

When the noncustodial parent changes jobs, the previous employer must notify the court or agency that entered the withholding order and provide specified information. The State must notify the new employer or income source to begin withholding from the obligor's wages.

In addition, States must develop procedures to terminate income withholding orders, for example, when all of the children are emancipated and no arrearage exists.

The Family Support Act requires immediate income withholding to begin in 1990 for all new or modified orders being enforced by the State's CSE agency and in 1991 for all persons in the CSE system. Immediate income withholding has been enacted by about half of the States.

PROPERTY LIENS

The use of liens for child support enforcement was characterized during congressional debate on Public Law 98-378 as "simple to execute and cost effective * * * and a catalyst for an absent parent to pay past due support in order to clear title to the property in question." (H. Rept. 527, 98th Cong., 1st sess., 1983) The report said that liens would complement the income withholding provisions of the 1984 law and be particularly helpful in enforcing support payments owed by noncustodial parents with substantial assets or income but who are not salaried employees.

Public Law 98-378 required States to enact laws and implement "procedures under which liens are imposed against real property for amount of overdue support owed by an absent parent who resides or owns property in the State." This can apply to such things as land, vehicles, houses, antique furniture, livestock, etc. The law provides, however, that States need not use liens in cases where, on the basis of guidelines that generally are available to the public, it determines that lien procedures would be inappropriate. This provision implicitly requires States to develop guidelines about use of liens.

Generally, a lien for delinquent child support is a statutorily created mechanism by which an obligee (i.e., custodial parent) obtains a nonpossessory interest in property belonging to the noncustodial parent. The interest of the custodial parent is a slumbering interest that allows the noncustodial parent to retain possession of the property, but affects the noncustodial parent's ability to transfer ownership of the property to anyone else. A child support lien converts the custodial parent from an unsecured to a secured creditor. As such, it gives the custodial parent priority over unsecured creditors and subsequent secured creditors. In some States a lien is established automatically upon entry of a support order and the first incidence of noncompliance by the obligor. Frequently, the mere imposition of a lien will motivate the delinquent parent to do whatever is necessary to remove the lien (i.e., pay past due support). When this is not the case, it may become necessary to enforce the lien. Liens are not self-executory. They merely impede the debtor's ability to transfer property. If a lien exists, a debtor must satisfy the judgment before the property may be sold or transferred. However, it is not necessary for the obligee to wait until the obligor tries to transfer the property before taking action. The obligee may enforce his judgment by execution and levy against the property if he believes that the amount of equity in the property justifies execution.

Several States have increased their use of liens by identifying individuals who possess appropriate assets through use of information obtained from Project 1099. Project 1099 is a cooperative effort involving State CSE agencies, the OCSE, and the IRS. It is named after the IRS form on which both earned and unearned income is reported. (Examples of reported earned and unearned incomes include: interest paid on savings accounts, stocks and bonds, and distribution of dividends and capital gains; rent or royalty payments; prizes, awards, or winnings; fees paid directors or subcontractors; and unemployment compensation.) Project 1099 was initiated in 1984 to assist in location efforts. Since fall 1988, project 1099 routinely provides wage and employer information as well as location and asset information on noncustodial parents.

CREDIT BUREAU REPORTING

Public Law 98-378 requires that States establish procedures for reporting overdue child support obligations exceeding $1,000 to consumer reporting agencies (generally referred to as credit bureaus), if such information is requested by the credit bureau. States have the option of using such procedures in cases where the noncustodial parent is less than $1,000 in arrears. (Moreover, as in the case of liens, this collection procedure need not be used in cases found inappropriate under State guidelines.) The 1984 law requires States to provide the noncustodial parent an advance notice of its intent to release information regarding his child support arrearage and an opportunity for him to contest the accuracy of the information. The CSE agency may charge the credit bureau a fee for the information.

Although some States and counties had agreements in place with credit bureaus to obtain information about the location of absent parents, the 1984 provision authorizes the routine transfer of information concerning overdue child support to credit bureaus on a much broader basis. Moreover, it is in the interest of credit bureaus to request such information because overdue child support adversely affects an obligated parent's ability to pay other debts.

FEDERAL GARNISHMENT

The 1975 CSE legislation included a provision allowing garnishment of wages and other payments by the Federal Government for enforcement of child support and alimony obligations. The 1975 law provides that moneys (the entitlement to which is based upon remuneration for employment) payable by the United States to any individual are subject to legal proceedings brought for the enforcement against such individual of his legal obligation to provide child support or make alimony payments. The law sets forth in detail the procedures that must be followed for service of legal process and specifies that the term "based upon remuneration for employment" includes wages, periodic benefits for the payment of pensions, retirement or retired pay (included social security and other retirement benefits), and other kinds of Federal payments. The following Federal income sources may not be garnished: any payment as compensation for death under any Federal program, Federal black lung benefits, veterans' pensions or compensation benefits for a service-related disability or death, and amounts paid to defray employment-related expenses.

MILITARY ALLOTMENTS

Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982, requires allotments from the pay and allowances of any member of the uniformed service (on active duty) when he fails to make child (or child and spousal) support payments. The requirement arises when the service member fails to make support payments in an amount at least equal to the value of 2 months' worth of support. Provisions of the Federal Consumer Credit Protection Act apply, limiting the percentage of the member's pay that is subject to allotment. The amount of the allotment is the amount of the support payment, as established under a legally enforceable administrative or judicial order.

INTERSTATE ENFORCEMENT

State laws require parents to be responsible for the financial support of their children. During the 1930's and 1940's, such laws were used to establish and enforce support obligations when the noncustodial parent, custodial parent, and child lived in the same State. But when noncustodial parents lived out of State, enforcing child support was cumbersome and ineffective. Often the only option in these cases was to seek to extradite the noncustodial parent and, when successful, to jail the person for nonsupport. Extradition is the process used to bring an obligor charged with or convicted of a crime (in this case, criminal nonsupport) from an asylum State back to the State where the children are located. This procedure, rarely used, generally punished the irresponsible parent, but left the abandoned family without financial support.

A University of Michigan study of separated parents nationwide found that 12 percent lived in different States 1 year after divorce or separation. That proportion increased to 25 percent 3 years after, and to 40 percent 8 years after. Estimates based on the Federal income tax refund offset program and other sources suggest that approximately 30 percent of child support cases involve interstate residency of the custodial and noncustodial parents.[4]

Uniform Reciprocal Enforcement of Support Act (URESA)

Since 1950, interstate cooperation has been promoted through the adoption by the States of URESA. This act, which was first proposed by the National Conference of Commissioners on Uniform State Laws in 1950, has been enacted, in substance, in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The act was amended in 1952 and 1958 and revised in 1968.

It is generally maintained that the increasing number of children who received AFDC benefits because of the absence of their father, together with the more frequent instances in which the father lived in another State, led many States to quickly adopt URESA. In 1940, 30.3 percent of AFDC children had an able-bodied father who was living away from the home. By 1950, the figure had reached 49.3 percent. About 32 States had enacted the original version of URESA within 5 years of its promulgation by the National Conference.

The purpose of URESA was to provide a system for the interstate enforcement of support orders without requiring the person seeking support to go (or have her legal representative go) to the State in which the noncustodial parent resided. Where the URESA provisions between the two States are compatible, the law can be used to establish paternity, locate an absent parent, and establish, modify, or enforce a support order. However, some observers note that the use of URESA procedures often result in lower orders for both current support and arrearages. They also contend that few CSE agencies attempt to use URESA procedures to establish paternity or to obtain a modification in a support order.

Long-arm statutes

Unlike URESA, interstate cases established or enforced by long-arm statutes use the court system in the State of the custodial parent rather than that of the noncustodial parent. When a person commits certain acts within a State, that person may be subjecting himself to the jurisdiction of that State, even if he does not live in that State. The long-arm of the law of the State where the event happens may reach out to grab the out-of-State person so that issues relating to the event may be resolved where it happened. Under the long-arm procedure, the State must authorize by statute that the acts allegedly committed by the defendant are those that subject the defendant to the State's jurisdiction. An example is a paternity statute stating that if conception takes place in the State and the child lives in the State, the State may exercise personal jurisdiction over the alleged father. Long-arm statute language usually speaks of extending the State's jurisdiction over an out-of-State defendant to the maximum extent permitted by the U.S. Constitution under the Fourteenth Amendment's Due Process Clause. Long-arm statutes may be used to establish paternity, establish support awards, and enforce support orders.

---

[4] Weaver, Ray L., and Robert G. Williams. "Problems With URESA: Interstate Child Support Enforcement Isn't Working But Could." Paper prepared for ABA Third National Child Support Conference, May 10–12, 1989. Washington, American Bar Association 1989, p. 510 [Hereafter cited as Weaver and Williams, "Problems With URESA"]

Federal courts

The 1975 CSE law mandated that the State plan for CSE require States to cooperate with other States in establishing paternity, locating absent parents, and securing compliance with court orders and authorized the use of Federal courts as a last resort to enforce an existing order in another State if that State were uncooperative.

Federal law allows the U.S. district courts to be used for the enforcement of child support orders in interstate cases. If another State fails to undertake to enforce a child support order on behalf of the requesting State within a reasonable time, the requesting State may ask the OCSE to certify the case for use of the Federal courts. If the application meets certain procedural requirements and it is determined that use of the Federal courts is the only reasonable method of enforcing an order, the case is to be certified for action by the U.S. district court. (OCSE officials say that Federal courts also can establish support orders.)

Section 460 of the Social Security Act says that the district courts of the United States shall have jurisdiction, without regard to any amount in controversy, to hear and determine any civil action certified by the Secretary of DHHS under section 452(a)(8) of the act. A civil action under section 460 may be brought in any judicial district in which the claim arose, the plaintiff resides, or the defendant resides. Section 452(a)(8) says that the Secretary of DHHS shall receive applications from States for permission to use the courts of the United States to enforce court orders for support against noncustodial parents and, upon a finding that (A) another State has not undertaken to enforce a court order of the originating State against the noncustodial parent within a reasonable time, and (B) that using the Federal courts is the only reasonable method of enforcing such order, approve such applications.

As a condition to obtaining the certification from the Federal OCSE, the CSE agency of the initiating State must give the CSE agency of the responding State at least 60 days after first seeking assistance in enforcing the order, a 30-day warning of its intent to seek enforcement in Federal court. If the initiating State receives no response within the 30-day limit, or if the response is unsatisfactory, the initiating State may apply to the OCSE Regional Office for certification. The application must attest that the above requirements have been satisfied. Upon certification of the case, a civil action may be filed in the U.S. District Court. Although this interstate enforcement procedure has been available since enactment of the CSE program, there has only been one reported case of its use by a State (the initiating State was California, and the responding State was Texas).

Interstate income withholding

Interstate income withholding is a process in which the State of the custodial parent seeks the help of the State in which the noncustodial parent's income is derived to enforce a support order using the income withholding mechanism. Pursuant to Public Law 98-378, income withholding availability has been universal for all valid in-State or out-of-State orders issued or modified after October 1, 1985, and for all orders in CSE cases regardless of the date the order was issued. Although Federal law requires a State to enforce another State's valid orders through interstate income withholding, there is no Federal mandate that interstate income withholding procedures be uniform. Approaches vary from the Model Interstate Income Withholding Act to URESA registration. The preferred way to handle an interstate income withholding request is to use the interstate action transmittal form from one CSE agency to another. In CSE cases, Federal regulations required that by August 22, 1988, all interstate income withholding requests be sent to the enforcing State's central registry for referral to the appropriate State or local official. The actual wage withholding procedure used by the State in which the noncustodial parent lives is the same as that used in intrastate cases.

States decide whether or not to make interstate income withholding available in non-CSE cases. Some States do not allow non-CSE interstate income withholding, insisting that all such requests be channelled through the CSE agency. In those States, it is necessary for a private attorney to refer his client to the local CSE office.

1988 law

Public Law 100-485 includes some provisions affecting interstate child support enforcement. The new law requires the establishment of a 15-member commission to study interstate child support establishment and enforcement. The commission is required to report its findings and recommendations to Congress by May 1, 1991. The duties of the commission include submitting recommendations to revise the URESA. The new law also requires States to establish automated statewide, comprehensive case tracking and monitoring systems, which should improve each State's ability to manage interstate cases.

Other procedures that aid interstate enforcement

In 1948, the National Conference of Commissioners on Uniform State Laws and the American Bar Association approved the Uniform Enforcement of Foreign Judgments Act (UEFJA). Revised in 1964 and adopted in only 30 States, UEFJA provides that upon the filing of an authenticated foreign (i.e., out-of-State) judgment and notice to the obligor, the judgment is to be treated in the same manner as a local one. A judgment is the official decision or finding of a court on the respective rights of the involved parties.

UEFJA applies only to judgments entitled to full faith and credit in the rendering State. As a general rule, child support arrearages that have been reduced to judgment, and arrearages that are not subject to retroactive modification in the rendering States are final judgments and thus entitled to finding under UEFJA. All States should now have legislation generally prohibiting the retroactive modification of child support arrears.

SUMMARY INFORMATION ON COLLECTION TECHNIQUES

Table 6 shows the percentage of child support collections obtained through the use of selected enforcement techniques. According to the OCSE, most CSE collections come from noncustodial parents who are complying with their support orders. However, the information is not provided in the OCSE annual report, which identifies only collection techniques that are concentrated on delinquent payments. The report for fiscal year 1990 shows that 54 percent of the $6.0 billion in child support payments collected that year was obtained through the more publicized enforcement techniques: wage withholding, Federal income tax refund offset, State income tax refund offset, and unemployment compensation intercept. The remaining 46 percent is listed as collected by other means. Officials said most of these other collections come from noncustodial parents who were complying with their support orders by sending their payments to the CSE agency. The other category also included collections from noncustodial parents who voluntarily sent money for their children even though a support order had never been established for them (1.4 percent of all collections), and other enforcement techniques, such as liens against property, by posting of bonds or securities, and use of the full IRS collection procedure.

TABLE 6.—CHILD SUPPORT COLLECTIONS MADE BY VARIOUS ENFORCEMENT TECHNIQUES, FISCAL YEAR 1988–90

[In millions]

Enforcement techniques	Child support collections			Percent of total collections		
	1988	1989	1990	1988	1989	1990
Wage withholding	$1,674	$2,144	$2,635	36.3	40.9	43.7
Federal income tax offset	370	411	444	8.0	7.8	7.4
State income tax offset	64	62	70	1.4	1.2	1.2
Unemployment compensation intercept	42	54	80	.9	1.0	1.3
Other [1]	2,463	2,578	2,806	53.4	49.1	46.4
Total collections	4,613	5,250	6,035	100.0	100.0	100.0

[1] The OCSE does not designate the source of most of these collections. According to the OCSE, the majority of collections in the other category came from noncustodial parents who were complying with their support orders by sending their payments to the CSE agency. Moreover, the OCSE officials maintain that responsibility of collection data lessen when specified by techniques of collection.

Source: U.S. Department of Health and Human Services. Office of Child Support Enforcement. "Child Support Enforcement Statistics, Fiscal Year 1990. Fifteenth Annual Report to Congress for the Period Ending September 30, 1990," v. II. [Advance Copy]

BANKRUPTCY AND CHILD SUPPORT ENFORCEMENT

The 1975 child support legislation included a provision that stated that an assigned child support obligation was not discharged in bankruptcy (i.e., a person filing bankruptcy was not relieved of his child support obligation). In 1978 this provision was repealed and incorporated into the 1978 uniform law on bankruptcy. The bankruptcy law also listed exceptions to discharge including alimony, maintenance or support due a spouse, former spouse, or child of the debtor in connection with a separation agreement, divorce decree, or property settlement. In 1981, the provision stating that a child support obligation assigned to the State as a condition of AFDC eligibility is not dischargeable in bankruptcy was reinstated. In 1984, a provision was enacted that provided that child support obligations that have been assigned to the State as part of the CSE program may not be discharged in bankruptcy, regardless of whether they are on behalf of an AFDC family or a non-AFDC family and regardless of whether the debtor was married to the child's other parent.

LINKAGE BETWEEN AFDC AND CHILD SUPPORT ENFORCEMENT

The Social Security Act requires every State operating an AFDC program to run a CSE program. Federal law requires applicants for, and recipients of, AFDC to assign their support rights to the State in order to receive AFDC. In addition, each applicant or recipient must cooperate with the State if necessary to (1) establish the paternity of a child born outside of marriage, and (2) obtain child support payments, unless it is found not to be in the best interest of the child to do so.

Under the law, AFDC recipients or applicants may be excused from the requirement of cooperation if the AFDC agency determines that good cause for noncooperation exists, taking into consideration the best interests of the child on whose behalf aid is claimed. The determination is made according to standards in Federal regulations, the so-called good cause regulations. If good cause is found not to exist and if the relative with whom a child is living still refuses to cooperate, the relative is to be disqualified from AFDC and the child's benefits are to be sent in the form of a protective payment to a person other than the caretaker relative. (The same is true of refusal to assign to the State support rights: the child will not be disqualified from AFDC, but will receive AFDC benefits only in the form of protective payments.) Circumstances under which cooperation may be found to be against the best interests of the child are defined to include: situations in which cooperation is reasonably anticipated to result in physical or emotional harm to the child, or physical or emotional harm to the caretaker relative, of such nature that it reduces the capacity to care for the child adequately; situations in which the child was conceived as a result of incest or rape; and situations in which legal procedures are underway for the child's adoption. Families who do not receive

AFDC assistance also are eligible for CSE and paternity determination services if they apply for services.

FUNDING

The Federal Government currently reimburses each State 66 percent of the cost of administering its CSE program. When the program began in 1975, the Federal match was 75 percent. In 1982, Public Law 97–248 reduced the Federal match to 70 percent (fiscal years 1983–87). In 1984 Public Law 98–378 reduced the Federal match to 68 percent in fiscal year 1988 and fiscal year 1989, and to 66 percent in fiscal year 1990 and years thereafter. These costs include moneys for locate services, paternity establishment, establishment of child support orders, and enforcement services.

The Federal Government also pays 90 percent of State costs of developing and improving management information systems, including expenditures on the hardware (i.e., computers) and 90 percent of laboratory costs incurred in determining paternity.

The Federal Government pays most of the costs of State CSE programs. States receive Federal funds to pay a majority share of the costs of operating CSE programs plus Federal incentive payments based on total collections and cost-effectiveness of their programs. State programs receive additional funding from the State government. Although the actual dollars contributed by the Federal Government are greater, the level of funding allocated by the State or local government determines the amount of resources available to the CSE agency.

INCENTIVE PAYMENTS TO STATES

In most States, the State share of CSE collections made on behalf of AFDC families can be calculated by subtracting the Federal medical assistance percentage from 100 percent (in some States, local governments also are entitled to part of the State's share of collections). In addition, States and localities receive Federal CSE incentive payments that come entirely from the Federal share of child support collections. The new incentive formula, effective October 1, 1985, was designed to encourage States to develop CSE programs that emphasize collections on behalf of both AFDC and non-AFDC families, and to improve the program's cost effectiveness.

Under the new incentive formula, each State receives an incentive payment equal to at least 6 percent of the State's total amount of AFDC support collections for the year, plus at least 6 percent of the State's total amount of non-AFDC collections for the year. The amount of the State's incentive payment could reach a high of 10 percent of the AFDC collections plus 10 percent of the non-AFDC collections, depending on the State's ratio of child support collections to administrative costs. (See table 7.)

TABLE 7.—INCENTIVE PAYMENT STRUCTURE

	Incentive payment received (percent)
Collection-to-cost ratio:	
Less than 1.4 to 1	6.0
At least 1.4 to 1	6.5
At least 1.6 to 1	7.0
At least 1.8 to 1	7.5
At least 2.0 to 1	8.0
At least 2.2 to 1	8.5
At least 2.4 to 1	9.0
At least 2.6 to 1	9.5
At least 2.8 to 1	10.0

There is a limit, however, on the incentive payment for non-AFDC collections. The incentive payments for such collections may not exceed 115 percent of incentive payments for AFDC collections. (This percentage was 100 percent in fiscal year 1986 and fiscal year 1987, 105 percent in fiscal year 1988, 110 percent in fiscal year 1989, and 115 percent in fiscal year 1990 and each year thereafter.)

The new incentive formula seeks to assure that States provide equitable treatment for both AFDC and non-AFDC families. Under the old system, a State that incurred administrative costs to collect support for a non-AFDC family did not receive an incentive payment since incentives were paid only for AFDC collections. This practice generally resulted in the neglect of non-AFDC cases. The new incentive formula aims to remedy that by making payments for non-AFDC collections. At the same time it has placed a limit on non-AFDC incentive payments so as to lessen the possibility that States would merely transfer to the CSE program child support activities which were previously financed out of State and/or local moneys, with no increase in the level of child support services.

At State option, laboratory costs (for blood testing, etc.) to establish paternity may be excluded from the State's administrative costs in calculating the State's collection-to-cost ratios for purposes of determining the incentive payment. In addition, for purposes of calculating these ratios, interstate collections are credited to both the initiating and responding States. Incentives are paid according to the collection-to-cost ratios (ratio of AFDC collections to total administrative costs and ratio of non-AFDC collections to total administrative costs) shown in table 5.

Before 1984, a State that initiated a successful action to collect child support from another State generally did not receive an incentive payment. Rather, the jurisdiction that made the collection received the incentive payment. Public Law 98–378 provides that both States involved in an interstate collection be credited with the collection for purposes of computing incentive payments. This double-counting is intended to encourage States to pursue interstate cases as energetically as they pursue intrastate cases. States now will pay incentive for interstate cases to themselves out of the Federal share of collections they distribute.

In addition to substantial Federal reimbursement, States may use fees and cost recovery to help finance the CSE program (discussed later). Such fees and costs recovered from non-AFDC cases must be subtracted from the State's total administrative cost before calculating the Federal reimbursement amount; however, the lower administrative cost figure may result in greater Federal incentive payments by improving the State's collection-to-cost ratio.

PAYMENTS TO AFDC FAMILIES

Families receiving AFDC benefits automatically qualify (free of charge) for CSE services. Their cases are referred to the CSE agency. Federal law requires AFDC families (and applicants), as a condition of eligibility for aid, to assign their support rights to the State, to cooperate with the State in establishing the paternity of a child born outside of marriage, and to cooperate with the State in obtaining support payments. The provision requiring the AFDC applicant or recipient to assign to the State her rights to support covers both current support and any arrears which have accrued, and lasts as long as the family receives AFDC. When the family no longer receives AFDC, the mother or caretaker relative regains her right to collect current support, but if there are arrears, the State may claim those arrears up to the amount paid out as AFDC benefits.

Child support payments made on behalf of a child receiving AFDC are supposed to be paid to the CSE agency rather than directly to the family. If the child support collection is insufficient to disqualify the family from receiving AFDC payments, the family receives its full monthly AFDC grant plus the first $50 of the child support payment made in the child's behalf for that month. The remainder of that monthly child support payment is distributed to reimburse the State and Federal Governments in proportion to their assistance to the family. If the family's income, including the child support payment, is sufficient to make the family ineligible for AFDC payments, the family's AFDC benefits are ended, and future child support payments are paid directly from the noncustodial parent to the family.

Supplemental payments in "fill-the-gap" States

Notwithstanding the above procedures, some States are required to provide monthly supplemental payments to AFDC recipients who have less disposable income now than they would have had in July 1975 because child support is paid to the CSE agency instead of directly to the family. States required to pay supplemental payment are often referred to as "fill-the-gap" States. These States pay less assistance than their full need standard, and allow recipients to use child support income to make up all or part of the difference between the payment made by the State and the State's need standard.

Section 402(a)(28) of the Social Security Act requires States that had a fill-the-gap policy in 1975 and currently have such a policy, to add to the AFDC benefit all or part of the child support collection (the amount which would have caused no reduction in the AFDC benefit it if had been paid directly to the family).

Information obtained from the Office of Child Support Enforcement (June 1990) indicates that seven States that had fill-the-gap policies in July 1975 also have them now and thus must follow the benefit calculation rules of section 402(a)(28) when taking account of child support collections for AFDC families. They are: Georgia, Maine, Mississippi, South Carolina, Tennessee, Virginia, and Wyoming. Another 13 jurisdictions, which had fill-the-gap policies in July 1975, no longer have them. Were they to resume a fill-the-gap practice, they also would be required to treat child support collections as though they were paid directly to the family. These jurisdictions are: Alabama, Alaska, Arizona, Arkansas, Delaware, Indiana, Missouri, New Mexico, Puerto Rico, Texas, Virgin Islands, Washington, and West Virginia.

PAYMENTS TO NON-AFDC FAMILIES

Families who do not receive AFDC assistance also are eligible if they apply for services, unless they have left the AFDC rolls and are automatically provided continued CSE services.

The entire amount of child support payments collected on behalf of a non-AFDC child is paid directly to the family. Even so, the State still receives the Federal reimbursement (currently 66 percent) for the costs of establishing and enforcing child support obligations for these non-AFDC cases. In some States, parents may be ordered by the court to make and receive support payments directly or through a court registry or State child support clearinghouse without any formal application to the CSE agency. When this occurs, the money collected, since it is outside the CSE system, cannot be counted in determining the amount of Federal reimbursement to the State.

Non-AFDC families participate in the CSE program on a voluntary basis, except for Medicaid-only cases. Federal funding for services to non-AFDC families was made a permanent part of the program in 1980 by Public Law 96-272. Federal law requires the State to charge an application fee of up to $25 for CSE services for non-AFDC families. Some States charge the full $25, some less, and others use State funds to pay the fee or seek collection from the noncustodial parent.

In addition, CSE agencies are allowed to recover the actual costs of their services to non-AFDC families from either the custodial parent or the noncustodial parent, once current support has been covered. In practice, this means that costs are deducted from arrears that otherwise would be paid directly to the non-AFDC client. Recovery of these costs is contingent on payment of the arrears. However, it is the practice of most States not to recover the cost of their services. The amount of fees collected by the States for purposes of processing non-AFDC cases plus the amount of processing costs recovered by the States in excess of the fees charged decreases the amount of States' expenditures eligible for Federal CSE funding. Moreover, any interest earned on money from fees or recovered costs is considered CSE program income and must be used by the States to offset program expenditures. In fiscal year 1989, fees received and costs recovered for non-AFDC cases amounted to $6.5 million.

Several States try to recoup costs in non-AFDC cases by deducting their costs from the actual child support payment before sending it to the custodial parent. Because some of these custodial parents are only dollars away from qualifying for AFDC and because it generally is easier to get on welfare than to earn one's way off, some policymakers argue that this practice can result in welfare dependency; others maintain that it is unfair to the children.

ARREARAGES

To receive AFDC benefits, a custodial parent must assign to the State her right to collect child support payments. This assignment covers current support and any arrears, and lasts as long as the family receives AFDC. When the family stops receiving AFDC, the assignment ends. The mother regains her right to collect current support. However, if there are arrears, the State may claim those arrears up to the amount paid out in AFDC. As described earlier, when a mother receives AFDC and the CSE agency makes a collection on her behalf, it must distribute the collection in accordance with Federal law. First, up to the first $50 collected is given to the family (a disregard that does not affect the family's AFDC benefit or eligibility status). Second, the Federal and State Governments are reimbursed for the AFDC benefits paid to the family in that month. Third, if there is money left, the family receives it up to the amount of the current month's child support obligation. Fourth, if there is still money left, the State keeps it to reimburse itself for any arrears owed to it under the AFDC assignment. If no arrears are owed the State, the money is used to pay arrears owed to the family. Such moneys are considered income under the AFDC program and would reduce the family's AFDC benefit.

In the case of non-AFDC families, the sequence is different. First, if the family never received AFDC, all child support collections made on the family's behalf are sent to the family. Second, if the family had received AFDC before, collections go toward payment on the current month's support obligation. If any money is left, it is considered in arrears and the State decides whether the arrears will be paid to the family or State first. If the arrears are paid to the State, they are distributed between the Federal and State Governments as reimbursement for past AFDC benefits. Third, if there are no arrears, the collection is credited toward future CSE payments.

According to the OCSE 14th annual report, in fiscal year 1989, the amount of total prior year support due, i.e., arrearages, amounted to $15.7 billion; $1.106 billion (7 percent) was paid in fiscal year 1989 on fiscal year 1988 arrears.

DISTRIBUTION OF COLLECTIONS

Collections made on behalf of families receiving AFDC directly offset AFDC benefit costs and (except for the first $50 of current monthly support payments, which go directly to the family, and are disregarded as income for AFDC purposes) are shared between the Federal Government and the States in accordance with the matching formula used for the individual State's AFDC program.

In general, the initial determination of the Federal share of CSE collections is based on the rate of Federal financial participation in AFDC benefit costs. The Federal share of AFDC benefit costs generally is determined by the Federal medical assistance percentage. The Federal share of AFDC benefit costs (and, therefore, the Federal share of CSE/AFDC collections) is inversely related to State per capita income; within limits, the lower the State per capita income, the greater the Federal share. Nationally, this figure is about 55 percent. It ranges from a minimum of 50 percent to a statutory maximum of 83 percent. In fiscal year 1992, the highest matching rate is 79.99 percent (the Federal match for AFDC benefit costs in Mississippi).

Even though the national average (gross) Federal share of AFDC collections is about 56 percent, Federal funds reimburse States for 66 percent of their CSE administrative costs. This lowers the net Federal share of support collections.

USE OF SUPPORT COLLECTIONS

The Federal share of child support collections paid by noncustodial parents of children receiving AFDC benefits is used first to pay incentives to States on their AFDC and non-AFDC collections. The remainder is used to offset Federal AFDC benefit costs. In fiscal year 1990, incentive payments amounted to $264 million, almost 50 percent of the Federal share of CSE collections. Payments made on behalf of non-AFDC families go to the family.

Neither Federal law nor regulations dictate the use of the State's share of child support savings; there are no Federal strings attached. However, child support collections in and of themselves can (1) prevent families from qualifying for welfare programs, (2) remove families from welfare rolls when the amount collected is sufficient, (3) partially offset State AFDC payments to families whose monthly child support is insufficient to remove them from welfare rolls, (4) recover or prevent the need for Medicaid payments through reimbursement from private health insurers in cases where the noncustodial parent has coverage, or where coverage is available, and (5) offset AFDC foster care costs. In addition, many States have chosen to reinvest child support savings back into the CSE program to increase the quality and effectiveness of the program. Some States use child support savings in other children and family programs. Others use child support savings wherever the State budget indicates the need. As noted earlier, some States have placed their CSE programs in their revenue department.

EXTENT TO WHICH FEDERAL GOVERNMENT BEARS COST OF THE CHILD SUPPORT ENFORCEMENT PROGRAM

One of the purposes of the CSE program is to reduce public expenditures on welfare by obtaining support from noncustodial parents on an ongoing basis. The CSE program also provides services to nonwelfare parents who apply for services. One purpose of the non-AFDC component of the program is welfare cost avoidance, that is, preventing families from going on AFDC (or other welfare programs) by collecting child support from noncustodial parents.

Even with the reduced Federal matching rate (from 75 percent in 1975 to 66 percent in 1990), the Federal Government has never recovered its costs from the CSE program. Under the current financing arrangement, States can run inefficient programs and still make a profit from the CSE program. The cost of the CSE program to the Federal Government, however, has continued, since 1984, to increase steadily.

To illustrate, assume that an inefficient State spends $200 to collect a $300 child support payment from a noncustodial parent whose children are receiving AFDC benefits. Such a State (with a collection-to-cost ratio of 1.5) would qualify for an incentive payment of $19.50 (6.5 percent of AFDC collections, see table 8). Since the State pays 34 percent of administrative costs, the collection would cost the State $68, but the State's share of the collection would total $144.50. This means that the State would pay 34 percent of the cost and get 48 percent of the collection. Thus, the net gain to the State would be $76.50.[5] On the other hand, the collection would cost the Federal Government $132, and its share of the collection would amount to $105.50. Thus, the collection would cost the Federal Government $26.50. In other words, the Federal Government would pay 66 percent of the cost and get 35 percent of the collection. The recipient would get nearly 17 percent of the collection (the $50 passthrough). Table 10 shows that although the CSE program is a net gain for the States, it is a significant net cost to the Federal Government.

TABLE 8.—STATE AND FEDERAL SHARE OF CHILD SUPPORT COLLECTIONS

[AFDC Family]

	Collections	Cost of collections	Net gain
State share	$125+$19.50=$144.50	$ 68	+$ 76.50
Federal share	125−19.50=105.50	132	−26.50
Payment to recipient	50.00	0	+ 50.00
Total	300.00	200	+100.00

The point at which a State breaks even (exactly recovers collection costs) in child support payments on behalf of AFDC recipients primarily depends on the share of AFDC benefit costs that it pays, and this, in turn, is related inversely to State per capita income. This can be shown by calculating the approximate breakeven ratios (collections needed per dollar of administrative cost) for States with different Federal AFDC matching rates, but the same collection cost per case. In the following examples, it is assumed that the cost of making a collection is $100 per month per AFDC case. This figure was chosen because it was the national average cost for fiscal year 1988; it was obtained by dividing total CSE administrative costs of AFDC cases by the average number of AFDC cases in which a collection was made.

---

[5] This is a simplified example. Actually, the State's share of savings is determined by adding the State's share of AFDC collections to the State's AFDC and non-AFDC incentive payments. Its share of total administrative costs is subtracted from these revenues. The calculations assume a 50-50 matching rate for AFDC benefits.

Example 1.—State that pays 50 percent of AFDC benefit costs—maximum State share. (In fiscal year 1990, 11 States and the District of Columbia were in this position.)

Under the existing system, the breakeven collection amount for a State spending $100 per AFDC case to collect child support payments, retaining the maximum State share (50 percent) of AFDC/CSE collections, paying the standard 34 percent of CSE administrative costs, and receiving the minimum incentive payment of 6 percent, is $105.[6] That is, the State need collect only $1.05 per $1 of total administrative cost in order to recover its share of costs. Conversely, the Federal breakeven ratio for this State's collections is approximately 2.17. That is, the State must collect about $217 in order for the Federal Government to break even.[7] (See table 9 and chart 1.)

Example 2.—State that pays the minimum share (less than 20 percent) of AFDC benefit costs.

This situation is illustrated by the case of Mississippi, which had a Federal matching rate of 80.18 percent (and, thus, a State matching rate of 19.82 percent) for AFDC benefit costs. The breakeven collection amount for Mississippi, assuming it also spent $100 per AFDC case to collect child support payments, would be $164. This is a breakeven ratio of 1.64. Conversely, the Federal breakeven ratio for Mississippi's CSE program is approximately 1.44. (See table 9 and chart 1.)

These illustrations show that the States that are entitled to a relatively small proportion of child support collections (because of paying a small share of AFDC benefit costs) have to collect more child support payments per administrative dollar than other States to recover their costs (other things being equal). (See table 9.)

---

[6] State share of collections = State share of costs at breakeven

$$.5(C-\$50) + .06[(C-\$50)+\$50] = .34Y$$

$$.56C = .34Y + \$25$$

Assume State receives 50–50 matching rate for AFDC benefit costs and assume $Y = \$100$ (national average in fiscal year 1988). C = total collections, Y = cost of collections, and $(C-\$50) = X$, which is the public share of collections. The incentive payment equals 6 percent of total collections.

[7] Federal share of collections = Federal share of costs at breakeven

$$.5(C-\$50) - .08[(C-\$50)+\$50] = .66Y$$

$$.42C = .66Y + \$25$$

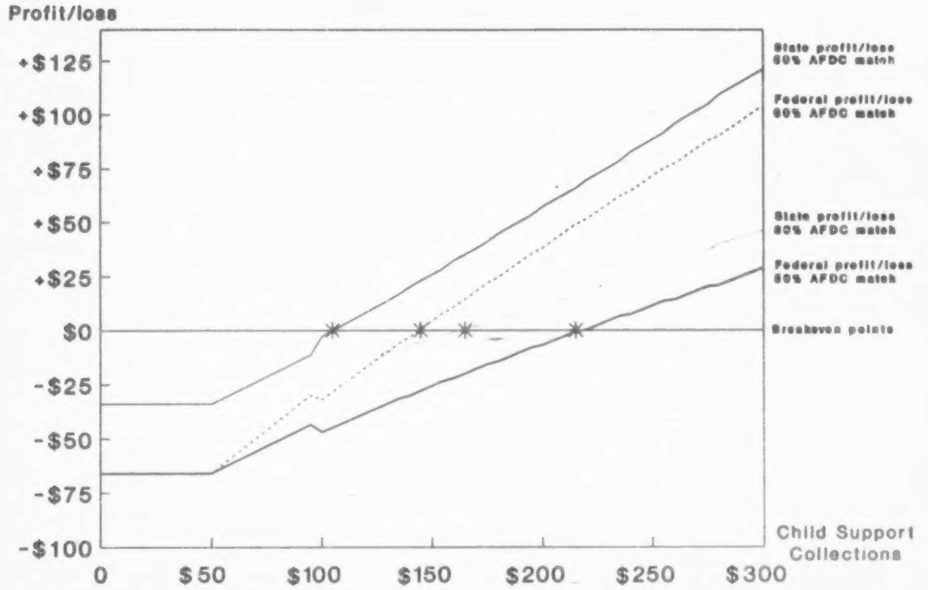
Assume State receives 50–50 matching rate for AFDC benefit costs and assume $Y = \$100$ (national average in fiscal year 1988). C = total collections, Y = cost of collections, and $(C-\$50) = X$, which is the public share of collections. The incentive payment, a function of the collection-to-cost ratio, equals 8 percent of total collections in this example where the collection-to-cost ratio is 2.17 (see table 7).

TABLE 9.—STATE AND FEDERAL BREAKEVEN POINTS PER DOLLAR OF COLLECTION COSTS [1] FOR SELECTED FEDERAL AFDC MATCHING RATES

	State breakeven	Federal breakeven
Federal AFDC matching rate:		
50 percent	$1.05	$2.17
60 percent	1.17	1.83
70 percent	1.36	1.60
80 percent	1.64	1.44

[1] The breakeven point is the amount of collections at which the jurisdiction exactly recovers its share of the collection costs. In this table collection costs are assumed to be $100 per month, the fiscal year 1988 national average cost of AFDC collections. This average was obtained by dividing fiscal year 1988 AFDC expenditures by the average number of AFDC cases in which a collection was made that year.

CHART 1. STATE/FEDERAL PROFIT/LOSS AT VARIOUS SUPPORT COLLECTION AMOUNTS, AND AFDC MATCHING RATES



Note: When a family's income, including child support payments, makes the family ineligible for AFDC benefits, future support payments are paid to the family, and the Federal/State distribution of collections no longer applies.
Source: Congressional Research Service. Education and Public Welfare Division.

Table 10 and chart 2 show that during the period 1979–90, the CSE program has produced new revenue for the States but caused a significant cost to the Federal Government. The States' share of collections has exceeded their share of administrative costs in each year, but the Federal share of collections has fallen increasingly short of their share of administrative costs. Net Federal costs have risen sharply from $42.6 million in fiscal year 1979 to $526.2 million in fiscal year 1990, a real increase of 486 percent (constant 1990 dollars). Although the difference between the State share of CSE collections plus incentive payments, minus the State share of administrative expenditures, State savings, increased in current dollars, from $243.5 million in fiscal year 1979 to $340.4 million in fiscal year 1990, there was a 22 percent decrease in constant 1990 dollars.

In fiscal year 1989, nine jurisdictions (Arizona, the District of Columbia, Guam, Mississippi, Nebraska, Nevada, Puerto Rico, the Virgin Islands, and West Virginia) did not achieve a savings from their CSE program. Moreover, in that same year, in only two States (Indiana and Montana) was the Federal share of child support savings positive. Despite the discussion above about breakeven points, it is not clear why these nine jurisdictions did not recover their costs from the CSE program, nor why the Federal Government recovered its costs in the two other States (mentioned above).

Table 10 also shows that the CSE program no longer produces a net public savings ($200.9 million savings in fiscal year 1979). Instead, in fiscal year 1990, the net cost of the program to the taxpayer was estimated at $186 million (a drop of 151 percent in real value), even though total CSE collections increased by 150 percent during the same period. In addition, table 8 shows public savings dropping 67 percent from fiscal year 1984 to fiscal year 1985. This sudden decrease in public savings primarily was caused by the provision in 1984 law, first effective in fiscal year 1985, requiring that up to the first $50 received by the CSE agency on behalf of an AFDC family be passed through to the family without affecting their eligibility for AFDC or AFDC benefit payments. In fiscal year 1985, about 3.5 percent of CSE collections, $93.8 million went to AFDC families (pursuant to the $50 passthrough rule). In fiscal year 1989, $306.6 million (about 5 percent of CSE collections) was passed through to AFDC families.

TABLE 10.—FEDERAL AND STATE SHARE OF CHILD SUPPORT "SAVINGS," FISCAL YEARS 1979–90

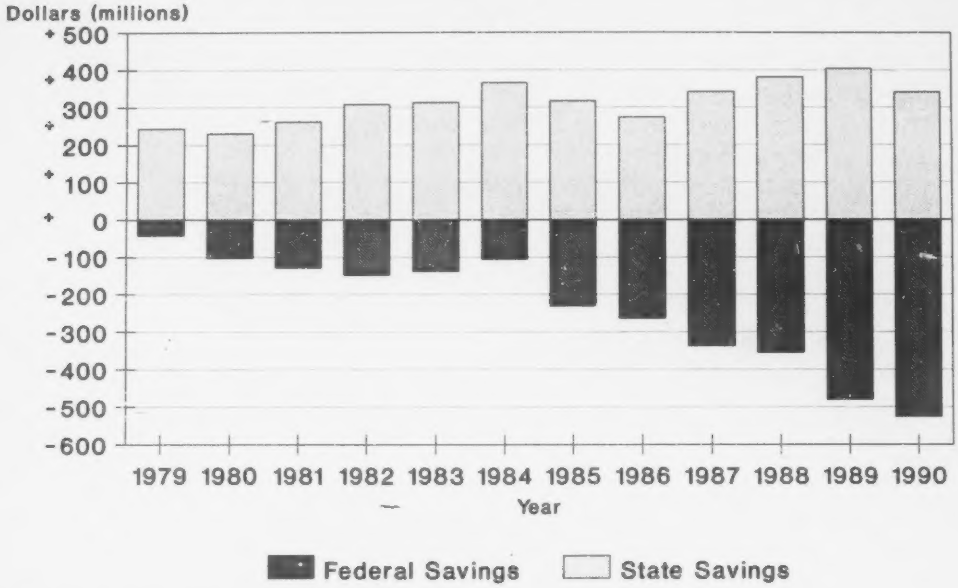
[In millions]

	Federal share of child support savings [1]	State share of child support savings	Net public savings
Fiscal year:			
1979	−$43	$244	$201
1980	−103	230	127
1981	−128	261	133
1982	−148	307	159
1983	−138	312	174
1984	−105	366	260
1985	−231	317	86
1986	−264	274	9
1987	−337	342	5
1988	−355	381	26
1989	−480	403	−77
1990	−526	340	−186

[1] Negative "savings" are costs.

Source: U.S. Department of Health and Human Services. Office of Child Support Enforcement. Annual Reports to Congress, various years.

CHART 2. FEDERAL AND STATE SHARE OF CHILD SUPPORT "SAVINGS," FISCAL YEARS 1979–1990



Note: Negative "savings" are costs.
Source: Annual Child Support Enforcement Reports to Congress, various years.

Some question whether States have sufficient incentive to minimize costs, most of which are paid by the Federal Government. However, others argue that the intangible benefits of the CSE program make it worthwhile, despite considerations of cost-effectiveness. It is a fact that a large segment of the program, namely the non-AFDC component, by definition, provides no direct savings to the States or the Federal Government. Nevertheless, the non-AFDC component of the CSE program can achieve welfare cost avoidance in the following ways: by providing non-AFDC families with additional income sufficient to make them decide not to apply for public assistance (AFDC, food stamp, or Medicaid), even though eligible; by making non-AFDC families ineligible for public assistance and by continuing to make these families ineligible by reason of income; and by reducing the benefit levels of non-AFDC families who do receive public assistance benefits.

A recent study indicated that there was $1 in indirect savings, or welfare cost avoidance, for every $5 in child support collections made on behalf of non-AFDC families.

It also should be noted that once the CSE system matures (i.e., once the majority of existing cases have child support orders), the cost-effectiveness of the system probably will improve. Moreover, because the benefits of establishing paternity or a child support award occur in future years as well as the current year, a static, point-in-time, analysis of costs and collections fails to account for the complexity and dynamic nature of the CSE system.

ROLE OF AUTOMATED SYSTEMS

In 1980, Congress authorized 90 percent Federal matching funds on an open-ended basis for CSE automated data systems, instead of the regular program rate (75 percent in 1980, 66 percent in fiscal year 1990 and years thereafter). Funds go to States that elect to establish an automated data processing and information retrieval system designed to assist management in the administration of the State plan, so as to control, account for, and monitor all factors in the support enforcement, collection, and paternity determination process. Funds may be used to plan, design, develop, and install or enhance the system. The Secretary of DHHS must approve the system as meeting specified conditions before matching is available.

In 1984, Congress made the 90 percent rate available to pay for the acquisition of computer hardware and necessary software. The 1984 legislation also specified that if a State met the Federal requirement for 90 percent matching, it could use its 90 percent matching funds to pay for the development and improvement of income withholding and other procedures required by the 1984 law.

In May 1986, the OCSE established a transfer policy requiring States seeking the 90 percent Federal matching rate to transfer existing automated systems from other States rather than to develop new ones, unless there were a compelling reason not to.

In 1988, Congress required States without comprehensive statewide automated systems to submit an advance planning document to the OCSE by October 1, 1991, for the development of such systems. All State systems must be approved as fully operating by October 1, 1995, at which time the 90 percent matching rate is to end. The new law allows many requirements for automated systems to be waived under certain circumstances. For instance, the DHHS Secretary may waive a requirement if (1) a State demonstrates that it has an alternative system enabling it to substantially comply with program requirements or (2) a State provides assurance that additional steps will be taken to improve its program.

As of February 1990, OCSE had certified five States' automated systems. These systems were at least partially operational in Connecticut, Delaware, Idaho, New York, and Vermont. Three other States, Colorado, New Jersey, and South Dakota, had certifications pending. Other States were in the planning, developing, or implementing stages, except ten States who were either developing their systems on their own under the regular administrative funding with only a 66 percent Federal matching rate, reexamining a suspended project, or not planning an automated system as yet.

According to the GAO report, States that develop automated systems with regular program funds also must obtain advance approval by the OCSE for expenditures that exceed $200,000. The GAO reported that oversight of system acquisition and operation under the regular program funding is less stringent than that of systems with enhanced funding.

IMPACT OF CHILD SUPPORT ENFORCEMENT ON AFDC AND POVERTY STATUS

For the 4.8 million women due child support payments in 1987 (including the 1.2 million women who did not receive any payment), the average annual amount of child support owed was $2,063. The average annual amount of child support for the 3.7 million women who received child support payments was $2,710. If the full amount of payment due had been made to all women owed child support, the average annual amount would have been $3,017. (The average AFDC benefit in 1987 was about $4,300.) In 1987, 1.2 million (39 percent) of the 2.8 million women raising children alone with incomes below the poverty level were supposed to receive child support payments. If full payment had been made to those 1.2 million women, 122,000 (3.8 percent of the 3.2 million and 9.9 percent of the 1.2 million) of them would have received enough income from child support payments to put them above the poverty level. This assumes that none of those poor women was a recipient of AFDC. For those receiving AFDC, the maximum they can receive in the form of child support payments (via the CSE agency) is $50 monthly.

It is clear from the above illustration that the low level of child support awards due in 1987 limited the CSE program's antipoverty impact. Only if a much higher percentage of mother-child families received support awards, as a result of improved cooperation of custodial parents and more expedited processes, in larger amounts, as a result of adequate support guidelines and keeping orders up to date, and only if these support orders were enforced diligently, might the CSE program enable a larger number of mothers and children to leave poverty (and/or AFDC). Even so, the antipoverty effectiveness of the CSE program still might be marginal for some families, given that Census Bureau data indicate that even being a member of a two-parent family is no guarantee against poverty. In 1989, 6.5 percent of white two-parent families with children under age 18 had incomes below the poverty level; 13.3 percent of black two-parent families were poor. This means that being in a two-parent family is not as much of a protection against poverty for blacks as it is for whites. Since the costs of achieving a moderate standard of living are sometimes higher for two households than for one, when a family breaks up, the father may have less money available to contribute to the support of his children. Thus, because the poverty rate of black children is relatively high even in two-parent families, the potential of child support for reducing the poverty rate of black children may be especially limited.

In 1987, $14.6 billion in child support payments was due, but actual payments totaled $10 billion.

In 1985, $10.9 billion in child support payments were due, but actual payments totaled $7.2 billion. This meant that $3.7 billion or 33 percent of collections owed in 1985 went unpaid. While the almost $11 billion owed in child support in 1985 is a substantial amount, two basic studies indicate that fathers have the ability to pay from $24 to $30 billion annually in child support. One study points out that the size of the estimate of the total amount that noncustodial fathers can afford to contribute to their children's maintenance ($26.6 billion annually) says nothing about the distribution of this money by income group. The study indicates that children whose fathers are in the highest income quintile would receive 46 percent of the $26.6 billion and that those whose fathers are in the lowest quintile would receive 3 percent of the $26.6 billion. However, another study based on data from the Panel Study of Income Dynamics, which covers divorces and separations during the period 1968–1981, indicates that poor children have not necessarily had poor fathers, and that increased child support payments from the absent fathers could substantially reduce their years of poverty. The study states that "the largest portion of the times when the custodial mother's family is poor are times when the absent father has enough income to keep himself and any new family he has formed out of poverty." This report concludes that if increased child support payments merely replace welfare support, many childhood years would remain years of poverty. It is important to remember that this study is based on data on divorced and separated couples only; whether such findings would apply to children whose parents had never married is not known. In short, it appears that child support payments per se are unlikely to lift the majority of families out of poverty or eliminate the need for welfare programs. Some of the reasons for this finding are: (1) the absence of support awards in a large number of cases, (2) nonpayment or underpayment of existing awards, and (3) low award levels relative to the income of noncustodial parents.

Although the antipoverty potential of the CSE program is limited and difficult to estimate, it is clear that child support payments could have a large impact on AFDC costs. In fiscal year 1990, the sum collected by the CSE agency from AFDC parents equalled 10.3 percent of AFDC benefits. Researchers say that this overstates the impact of the CSE program, inasmuch as AFDC mothers would have collected some support if there were no CSE program and they were not required to give their child support rights to the welfare agency. One researcher estimates that only about 25 percent of the gain can be attributed directly to the CSE program. (This figure, applied to fiscal year 1990, leads to the estimate that if there had been no CSE program that year, mothers would have collected almost 8 percent of AFDC benefits, compared to the actual sum of 10.3 percent collected by the CSE agency.) The researcher said that if a successful system of mandatory wage withholding were adopted and greater efforts made to establish obligations, the CSE program might recover between 15 percent and 20 percent of total AFDC benefit expenditures. The OCSE annual fiscal year 1990 data show 9 States recovering at least 20 percent of total AFDC benefit payments through the efforts of the CSE program (on average, these are relatively smaller States with low AFDC benefit levels). In fiscal year 1990, the OCSE reported that 239,000 families were removed from the AFDC rolls because of child support collections. This represented 6.3 percent of the families enrolled in the basic (one-parent) component of the AFDC program that year.

In addition, there is much research that indicates that child support payments could help reduce the severity of poverty for many non-AFDC children even if it did not end their poverty.

TABLE 11.—ESTIMATED TOTAL NUMBER AND PERCENT OF AFDC FAMILIES AFFECTED BY $50 PASSTHROUGH: 1985, 1987, 1989, AND 1990 [1]

State	AFDC (IVA) families 1990	Estimated families affected 1990	Percent of families affected			
			1985	1987	1989	1990
Alabama	45,322	8,638	11.7	18.5	21.1	19.1
Alaska	7,664	1,586	11.9	14.2	18.1	20.7
Arizona	43,127	2,105	4.8	4.2	4.7	4.9
Arkansas	24,721	4,863	15.9	20.4	21.3	19.7
California	572,761	72,350	13.8	10.1	10.7	12.7
Colorado	35,363	5,351	14.1	14.0	14.9	15.1
Connecticut	42,880	8,300	25.6	32.6	22.4	19.3
Delaware	8,223	1,482	21.7	24.3	18.9	18.0
District of Columbia	18,457	1,387	5.8	7.2	9.4	7.5
Florida	134,815	32,407	11.4	14.8	24.3	24.0
Georgia	101,849	19,993	5.3	11.7	17.5	19.6
Guam	1,136	226	10.5	9.7	11.5	19.9
Hawaii	13,854	1,338	20.5	15.1	19.6	13.2
Idaho	6,139	2,863	46.7	29.8	40.6	46.6
Illinois	199,171	15,631	5.5	8.7	6.6	7.9
Indiana	53,931	14,977	25.9	22.5	24.5	27.8
Iowa	32,624	7,443	22.7	19.4	20.0	22.8
Kansas	23,918	5,750	15.2	17.5	16.9	24.0
Kentucky	66,383	8,902	7.6	9.5	13.8	13.4
Louisiana	93,869	8,017	6.9	7.7	8.5	8.5
Maine	18,551	7,284	25.6	29.3	38.8	39.3
Maryland	66,333	7,201	15.0	13.5	8.3	10.9
Massachusetts	93,150	15,157	20.2	19.6	18.5	16.3
Michigan	193,683	49,003	17.2	31.7	20.2	25.3
Minnesota	49,839	13,961	22.5	20.1	22.8	28.0
Mississippi	60,023	5,526	4.8	5.7	7.5	9.2
Missouri	67,313	12,469	8.2	10.1	15.5	18.5
Montana	8,779	1,332	13.9	10.7	12.3	15.2
Nebraska	13,660	2,811	11.3	15.4	18.9	20.6
Nevada	8,147	2,431	33.6	35.4	32.5	29.8
New Hampshire	6,261	845	12.6	18.7	16.6	13.5
New Jersey	104,624	16,479	15.4	15.9	12.6	15.8
New Mexico	21,315	2,514	7.6	7.4	10.3	11.8
New York	335,208	39,547	9.2	10.8	10.8	11.8
North Carolina	86,252	16,795	15.0	18.0	21.4	19.5
North Dakota	5,565	2,043	25.1	26.7	31.4	36.7
Ohio	203,140	40,379	11.6	11.8	19.2	19.9
Oklahoma	38,810	5,191	8.4	10.2	12.3	13.4

TABLE 11.—ESTIMATED TOTAL NUMBER AND PERCENT OF AFDC FAMILIES AFFECTED BY $50 PASSTHROUGH: 1985, 1987, 1989, AND 1990 [1]—Continued

State	AFDC (IVA) families 1990	Estimated families affected 1990	Percent of families affected			
			1985	1987	1989	1990
Oregon	31,599	5,575	16.0	19.6	17.7	17.6
Pennsylvania	170,489	35,513	16.3	18.8	19.7	20.8
Puerto Rico	59,264	2,464	4.7	4.4	4.6	4.2
Rhode Island	16,468	2,940	13.9	17.7	18.5	17.9
South Carolina	38,576	10,153	8.9	16.1	26.1	26.3
South Dakota	6,698	1,433	17.6	27.7	27.6	21.4
Tennessee	76,483	11,641	9.8	9.7	12.6	15.2
Texas	208,897	12,195	3.1	4.3	5.9	5.8
Utah	15,522	3,683	26.9	25.4	29.6	23.7
Vermont	7,066	2,577	21.9	25.8	34.7	36.5
Virgin Islands	884	103	10.2	14.4	14.2	11.6
Virginia	56,154	13,975	14.9	16.9	22.0	24.9
Washington	72,859	18,042	18.0	18.9	19.6	24.8
West Virginia	28,605	2,019	6.6	4.2	5.0	7.1
Wisconsin	70,954	27,583	37.8	23.5	34.0	38.9
Wyoming	5,281	1,146	8.0	10.4	14.0	21.7
Nationwide total	3,772,659	615,669	13.2	14.1	15.0	16.3

NA=Not available.

---

[1] These estimates are based on the number of "paying" child support cases and are a low estimate of the number of families affected.

Note: These estimates are based on the number of "paying" child support cases adjusted for comparability with AFDC families.

Source: Office of Child Support Enforcement.

TABLE 12.—STATE PROFILE OF COLLECTIONS AND EXPENDITURES, FISCAL YEAR 1990 [1]

[In millions of dollars]

State	Total collections	AFDC collections	Non-AFDC collections	Total expenditures
Alabama	$66.2	$19.5	$46.7	$23.8
Alaska	26.8	8.2	18.6	6.5
Arizona	27.8	6.1	21.7	18.7
Arkansas	26.0	11.8	14.2	9.3
California	522.6	248.4	274.2	201.8
Colorado	39.6	16.8	22.8	14.0
Connecticut	66.7	27.4	39.3	27.1
Delaware	20.2	5.8	14.3	6.4
District of Columbia	13.6	4.1	9.5	7.6
Florida	176.6	48.4	128.2	66.4
Georgia	113.1	45.9	67.2	36.9
Guam	1.4	.5	.9	1.2
Hawaii	27.6	8.3	19.3	7.6
Idaho	22.9	7.0	16.0	5.7
Illinois	136.0	44.1	91.9	52.1
Indiana	96.1	38.1	58.0	15.6
Iowa	71.0	28.6	42.4	14.2
Kansas	45.0	15.2	29.7	16.3
Kentucky	60.0	22.3	37.7	23.5
Louisiana	60.5	20.9	39.7	19.4
Maine	35.7	21.1	14.7	9.4
Maryland	151.4	42.3	109.0	39.8
Massachusetts	174.8	73.0	101.8	46.6
Michigan	644.7	145.3	499.5	82.4
Minnesota	139.3	44.0	95.4	38.9
Mississippi	30.5	14.5	16.0	19.6
Missouri	129.9	38.1	91.8	27.6
Montana	8.8	4.4	4.4	3.2
Nebraska	52.3	7.0	45.3	11.7
Nevada	16.2	3.3	12.9	7.7
New Hampshire	20.6	3.6	17.0	5.6
New Jersey	281.9	61.5	220.5	77.1
New Mexico	14.4	5.6	8.8	7.2
New York	371.5	133.8	237.7	146.5
North Carolina	120.3	46.2	74.2	37.9
North Dakota	10.4	5.1	5.3	2.9
Ohio	489.5	76.9	412.6	67.9
Oklahoma	32.2	11.9	20.3	14.1
Oregon	78.4	18.9	59.5	17.5
Pennsylvania	618.0	96.3	521.7	70.5
Puerto Rico	84.7	1.7	83.0	10.8
Rhode Island	20.0	10.2	9.9	7.9
South Carolina	52.3	15.9	36.4	20.1
South Dakota	11.0	3.7	7.3	2.8
Tennessee	71.5	22.9	48.6	16.7
Texas	147.9	39.7	108.3	68.7
Utah	38.1	15.0	23.1	12.3
Vermont	9.4	5.6	3.8	2.6
Virgin Islands	3.1	.2	2.9	.7
Virginia	110.6	27.8	82.8	47.1
Washington	175.7	65.3	110.5	56.2
West Virginia	21.7	4.1	17.6	7.9
Wisconsin	241.3	59.3	182.0	41.9
Wyoming	7.2	2.6	4.6	2.1
Total	$6,035.3	$1,753.8	$4,281.4	$1,606.1

[1] Totals may not add because of rounding.

Source: Office of Child Support Enforcement.

TABLE 13.—TOTAL CHILD SUPPORT COLLECTIONS, SELECTED FISCAL YEARS 1979–90

[In thousands of dollars]

State	1979	1981	1983	1985	1987	1989	1990
Alabama	6,854	5,021	8,643	25,532	39,976	56,876	66,174
Alaska	3,844	5,932	9,704	10,794	17,139	23,163	26,788
Arizona	6,411	8,755	10,563	12,874	20,114	24,306	27,837
Arkansas	3,921	4,856	7,401	9,988	16,267	22,708	26,010
California	199,945	201,426	254,586	305,096	394,882	469,084	522,646
Colorado	4,020	12,302	17,178	18,324	22,376	33,564	39,601
Connecticut	23,033	29,602	39,227	48,210	57,182	67,478	66,724
Delaware	5,814	6,945	8,097	10,698	13,871	18,047	20,161
District of Columbia	1,086	1,909	3,521	4,692	5,690	9,439	13,598
Florida	10,524	16,932	19,080	45,751	81,759	142,537	176,603
Georgia	5,554	8,304	13,439	26,281	48,082	88,830	113,095
Guam	160	149	391	433	627	823	1,440
Hawaii	5,150	7,547	10,087	11,642	15,985	19,607	27,638
Idaho	2,501	3,277	4,690	5,815	13,490	19,069	22,909
Illinois	10,740	13,943	32,025	54,530	89,622	112,930	136,019
Indiana	9,073	12,339	20,789	33,683	60,613	77,268	96,145
Iowa	13,017	21,522	29,185	34,350	48,516	62,448	70,982
Kansas	3,975	6,908	9,921	11,430	22,199	32,494	44,958
Kentucky	4,881	14,732	19,702	25,145	32,456	51,228	59,998
Louisiana	12,678	17,833	26,754	34,259	40,047	51,143	60,527
Maine	4,574	5,677	10,235	14,121	22,421	32,789	35,741
Maryland	20,856	35,193	77,129	83,807	97,889	128,753	151,352
Massachusetts	36,338	52,955	72,319	98,339	128,809	166,712	174,824
Michigan	248,414	305,396	273,799	341,178	531,137	610,723	644,734
Minnesota	21,370	29,988	44,893	58,850	79,467	121,301	139,345
Mississippi	1,662	2,510	4,887	6,895	15,444	24,257	30,532
Missouri	5,829	12,364	18,118	34,520	71,905	101,609	129,851
Montana	1,213	1,698	2,415	3,906	5,328	7,029	8,822
Nebraska	2,468	10,832	20,044	29,906	37,667	48,367	52,273
Nevada	3,487	4,011	5,556	7,280	9,844	13,131	16,210
New Hampshire	2,089	2,336	11,621	12,771	17,542	16,033	20,604
New Jersey	94,005	104,853	143,225	200,155	245,697	269,438	281,923
New Mexico	1,680	2,748	4,614	6,292	8,672	12,244	14,416
New York	136,361	141,670	174,454	199,550	269,218	325,868	371,489
North Carolina	9,168	17,196	30,830	45,042	69,768	102,843	120,344
North Dakota	1,723	1,936	2,723	3,645	5,483	8,414	10,414
Ohio	22,832	31,467	34,862	82,700	180,696	392,473	489,515
Oklahoma	1,826	3,224	5,233	9,233	16,365	26,099	32,169
Oregon	88,502	105,670	38,052	39,778	53,470	67,525	78,374
Pennsylvania	186,718	222,548	285,829	371,163	459,950	558,870	618,045
Puerto Rico	1,916	2,459	31,985	54,265	66,164	78,786	84,679
Rhode Island	3,575	3,772	7,196	8,634	11,823	16,206	20,044
South Carolina	3,545	5,323	7,461	11,063	33,581	46,276	52,320
South Dakota	1,407	1,768	2,847	3,154	6,275	10,329	11,024
Tennessee	8,976	10,217	19,077	23,562	38,406	58,840	71,502
Texas	8,207	11,633	17,941	30,311	61,184	109,789	147,939
Utah	6,624	9,710	13,594	16,759	24,766	33,069	38,071
Vermont	1,449	2,199	2,828	3,683	5,781	8,489	9,353
Virginia	9,197	9,904	13,617	16,278	3,018	3,084	3,131
Virgin Islands	260	429	684	2,339	58,859	95,708	110,560
Washington	27,018	31,756	41,643	56,830	72,320	127,264	175,750
West Virginia	1,592	2,349	3,434	4,691	9,724	18,298	21,658
Wisconsin	34,267	42,195	56,041	82,071	154,701	220,655	241,272
Wyoming	520	781	1,017	1,231	3,229	5,436	7,155
Nationwide total	1,332,847	1,629,000	2,024,184	2,693,528	3,917,498	5,249,751	6,035,288

Source: Office of Child Support Enforcement.

TABLE 14.—TOTAL DISTRIBUTED AFDC COLLECTIONS, SELECTED FISCAL YEARS 1979–90

[In thousands of dollars]

State	1979	1981	1983	1985	1987	1989	1990
Alabama	6,830	5,021	7,789	14,863	15,050	18,798	19,484
Alaska	334	772	1,780	2,058	4,242	6,877	8,160
Arizona	642	1,221	1,459	1,636	4,805	4,484	6,102
Arkansas	2,428	2,684	4,593	6,318	8,771	11,626	11,799
California	117,532	100,437	136,963	154,024	198,152	226,761	248,440
Colorado	3,525	4,505	9,330	9,372	11,155	14,870	16,765
Connecticut	11,416	15,684	20,628	23,606	26,403	30,309	27,405
Delaware	1,386	2,001	2,276	3,847	4,150	5,292	5,826
District of Columbia	907	1,379	2,421	2,609	2,912	3,608	4,118
Florida	8,598	12,289	10,408	26,261	33,511	42,151	48,364
Georgia	4,772	7,441	11,355	19,268	25,244	35,789	45,937
Guam	159	117	259	281	299	352	520
Hawaii	2,544	3,127	4,482	5,162	5,698	6,171	8,343
Idaho	2,047	2,659	3,806	4,324	5,034	6,123	6,952
Illinois	9,916	12,347	18,971	27,936	38,705	37,453	44,149
Indiana	8,116	10,129	17,646	24,585	31,466	37,235	38,124
Iowa	10,654	15,218	19,978	23,858	27,834	26,558	28,552
Kansas	3,454	5,279	7,807	9,781	12,155	12,864	15,209
Kentucky	4,615	4,314	6,316	9,440	11,676	18,653	22,286
Louisiana	5,244	7,429	9,641	13,043	15,798	19,489	20,861
Maine	4,133	4,732	8,402	10,528	15,557	20,841	21,089
Maryland	10,929	15,912	27,773	28,197	27,417	33,850	42,318
Massachusetts	29,145	38,243	40,476	46,343	53,962	69,660	72,977
Michigan	76,375	87,304	97,694	111,925	127,508	138,034	145,251
Minnesota	14,510	20,290	25,708	30,805	35,822	42,105	43,950
Mississippi	1,556	2,284	4,544	4,807	7,596	11,645	14,530
Missouri	4,165	6,423	11,500	16,978	23,525	30,765	38,056
Montana	685	1,039	1,834	3,195	3,365	3,925	4,394
Nebraska	2,083	3,022	3,675	5,863	6,160	6,672	6,990
Nevada	517	879	1,824	1,731	2,673	2,995	3,311
New Hampshire	2,089	2,220	2,649	2,523	2,744	3,002	3,606
New Jersey	28,622	31,985	41,103	51,155	58,890	61,741	61,473
New Mexico	1,160	1,907	2,891	3,750	4,120	5,140	5,573
New York	56,588	47,790	68,622	79,148	102,115	117,351	133,753
North Carolina	7,714	11,774	18,795	23,531	33,249	41,553	46,176
North Dakota	1,379	1,542	2,011	2,660	3,517	4,183	5,103
Ohio	21,974	30,494	33,403	47,585	66,866	70,576	76,888
Oklahoma	1,260	2,254	3,648	6,559	7,143	10,002	11,875
Oregon	12,977	13,305	12,645	14,123	14,744	16,888	18,877
Pennsylvania	33,190	37,381	47,135	62,791	77,932	92,903	96,328
Puerto Rico	439	717	917	1,525	1,803	1,646	1,707
Rhode Island	3,438	3,624	4,217	5,126	6,064	7,595	10,168
South Carolina	3,065	4,437	6,015	7,720	13,218	14,319	15,933
South Dakota	1,137	1,225	2,175	2,305	3,058	3,858	3,717
Tennessee	3,871	3,519	5,567	5,868	12,086	19,998	22,926
Texas	6,370	8,308	10,879	15,959	19,703	34,450	39,659
Utah	5,442	8,133	11,643	11,441	11,733	14,038	14,999
Vermont	1,201	1,939	2,626	3,162	4,183	5,162	5,578
Virginia	9,081	8,737	11,758	13,930	241	230	210
Virgin Islands	143	150	140	211	15,536	22,655	27,770
Washington	18,319	19,244	26,495	32,021	38,429	53,328	65,291
West Virginia	1,430	2,201	3,311	4,544	5,647	4,758	4,085
Wisconsin	26,044	33,029	39,582	48,721	57,468	60,072	59,303
Wyoming	379	536	790	793	1,489	1,849	2,584
Nationwide total	596,532	670,637	879,862	1,089,798	1,348,624	1,593,254	1,753,847

Source: Office of Child Support Enforcement.

TABLE 15.—TOTAL NON-AFDC COLLECTIONS, SELECTED FISCAL YEARS 1979–90

[In thousands of dollars]

State	1979	1981	1983	1985	1987	1989	1990
Alabama	16	698	854	10,669	24,926	38,078	46,691
Alaska	3,510	5,159	7,924	8,736	12,897	16,286	18,628
Arizona	5,769	7,534	9,104	11,238	15,309	19,822	21,735
Arkansas	1,494	2,172	2,808	3,670	7,496	11,081	14,211
California	82,412	100,989	117,623	151,072	196,730	242,323	274,205
Colorado	496	7,797	7,848	8,952	11,221	18,694	22,836
Connecticut	11,617	13,918	18,599	24,604	30,779	37,169	39,319
Delaware	4,428	4,943	5,821	6,850	9,721	12,755	14,335
District of Columbia	179	530	1,100	2,083	2,778	5,830	9,481
Florida	1,926	4,643	8,672	19,490	48,248	100,386	128,239
Georgia	783	863	2,084	7,013	22,838	53,040	67,158
Guam	([1])	32	131	152	327	471	920
Hawaii	2,606	4,420	5,605	6,480	10,287	13,436	19,295
Idaho	454	617	884	1,490	8,457	12,946	15,957
Illinois	823	1,596	13,054	26,594	50,917	75,477	91,870
Indiana	957	2,210	3,142	9,098	29,147	40,032	58,021
Iowa	2,363	6,304	9,701	10,492	20,682	35,890	42,430
Kansas	520	1,629	2,114	1,648	10,044	19,630	29,749
Kentucky	266	10,418	13,387	15,704	20,780	32,574	37,711
Louisiana	7,434	10,404	16,113	21,216	24,250	31,655	39,665
Maine	441	945	1,833	3,593	6,864	11,948	14,652
Maryland	9,927	19,281	49,356	55,609	70,473	94,903	109,034
Massachusetts	7,193	14,712	31,844	51,996	74,846	97,052	101,847
Michigan	172,039	218,092	176,105	229,254	403,629	472,689	499,483
Minnesota	6,861	9,698	19,184	28,045	43,645	79,196	95,395
Mississippi	106	226	343	2,088	7,848	12,612	16,002
Missouri	1,664	5,941	6,618	17,542	48,380	70,844	91,795
Montana	528	659	582	711	1,963	3,104	4,427
Nebraska	385	7,810	16,369	24,043	31,507	41,695	45,283
Nevada	2,970	3,132	3,731	5,549	7,172	10,136	12,899
New Hampshire	0	116	8,972	10,248	14,798	13,031	16,999
New Jersey	65,383	72,868	102,122	149,000	186,808	207,697	220,450
New Mexico	520	841	1,722	2,542	4,552	7,104	8,843
New York	79,773	93,880	105,831	120,402	167,103	208,517	237,736
North Carolina	1,454	5,422	12,035	21,511	36,519	61,290	74,167
North Dakota	344	394	712	986	1,966	4,231	5,312
Ohio	858	972	1,459	35,115	113,830	321,897	412,627
Oklahoma	566	970	1,585	2,674	9,222	16,097	20,293
Oregon	75,525	92,364	25,406	25,655	38,726	50,637	59,497
Pennsylvania	153,528	185,167	238,694	308,372	382,018	465,968	521,716
Puerto Rico	1,477	1,742	31,068	52,740	64,360	77,140	82,972
Rhode Island	137	148	2,979	3,508	5,759	8,612	9,876
South Carolina	480	886	1,446	3,342	20,363	31,957	36,387
South Dakota	270	543	672	848	3,217	6,472	7,307
Tennessee	5,105	6,626	13,510	17,694	26,321	38,841	48,575
Texas	1,837	3,325	7,062	14,353	41,481	75,339	108,280
Utah	1,183	1,577	1,952	5,317	13,032	19,031	23,073
Vermont	249	260	202	522	1,598	3,326	3,775
Virginia	116	1,167	1,858	2,347	2,777	2,853	2,920
Virgin Islands	116	278	544	2,128	43,323	73,053	82,789
Washington	8,699	12,512	15,148	24,808	33,891	73,937	110,459
West Virginia	162	147	123	147	4,076	13,540	17,574
Wisconsin	8,224	9,165	16,459	33,350	97,233	160,582	181,969
Wyoming	141	245	227	437	1,739	3,587	4,571
Nationwide total	736,315	958,291	1,144,322	1,603,730	2,568,874	3,656,498	4,281,441

[1] Less than $500.

Source: Office of Child Support Enforcement.

TABLE 16.—AVERAGE NUMBER OF AFDC CHILD SUPPORT ENFORCEMENT CASES IN WHICH A COLLECTION WAS MADE, SELECTED FISCAL YEARS 1978–90

State	1978	1979	1981	1983	1985	1987	1989	1990
Total	458,439	463,100	547,707	594,679	684,114	608,986	657,181	700,726
Alabama	7,966	21,489	18,398	16,301	9,133	11,572	12,316	10,860
Alaska	246	213	613	1,154	1,120	1,038	1,213	1,387
Arizona	819	906	1,094	1,164	1,851	1,470	2,545	3,128
Arkansas	2,509	2,641	3,019	3,683	5,207	5,506	6,278	6,372
California	92,325	76,460	86,859	86,277	103,742	74,081	84,367	89,304
Colorado	3,177	2,875	3,322	4,129	5,687	4,092	4,771	4,437
Connecticut	8,002	9,078	11,245	13,591	15,565	13,337	7,470	6,578
Delaware	1,156	1,704	2,313	2,254	2,891	2,858	2,111	2,223
District of Columbia	708	758	848	1,508	1,925	2,138	2,553	1,692
Florida	7,376	6,710	9,837	11,856	16,468	30,114	34,883	38,500
Georgia	6,350	6,023	7,360	7,826	6,657	10,710	14,833	19,310
Guam	(1)	(1)	102	186	206	197	182	339
Hawaii	1,757	1,869	2,319	2,718	4,622	3,175	3,831	2,658
Idaho	1,346	1,166	1,122	936	4,343	1,245	1,522	1,752
Illinois	9,624	10,348	13,717	15,551	18,299	14,352	14,986	16,968
Indiana	9,488	6,339	8,226	19,514	22,058	16,188	17,716	20,444
Iowa	8,396	9,684	11,245	10,135	11,871	7,015	7,241	7,289
Kansas	2,859	2,842	3,764	4,205	4,769	3,798	3,565	4,595
Kentucky	3,083	3,341	4,638	4,601	6,729	6,853	8,699	10,741
Louisiana	5,204	5,461	6,652	6,944	7,836	9,916	11,582	11,842
Maine	2,368	3,043	4,297	6,141	7,178	4,734	5,200	5,515
Maryland	14,002	12,840	15,063	15,576	15,861	9,073	5,250	9,237
Massachusetts	17,782	19,357	22,147	22,655	25,350	17,211	16,610	16,029
Michigan	61,985	66,270	70,851	73,442	59,049	58,364	47,388	51,747
Minnesota	9,818	9,145	13,854	12,891	14,872	12,442	13,822	14,192
Mississippi	1,846	2,033	2,757	3,216	3,742	4,544	6,006	7,237
Missouri	(2)	3,550	5,048	2,465	7,716	6,483	9,894	11,178
Montana	748	540	726	1,178	1,600	849	1,086	1,140
Nebraska	1,509	1,333	1,559	1,841	2,362	2,555	2,666	2,811
Nevada	494	492	1,976	2,261	2,370	1,645	1,917	2,269
New Hampshire	1,530	1,710	2,093	1,512	1,021	981	988	1,091
New Jersey	16,243	31,161	28,663	24,712	27,686	25,182	18,415	17,591
New Mexico	1,429	1,650	1,772	2,027	2,034	2,175	3,147	3,766
New York	36,287	37,914	36,450	44,168	48,979	30,993	36,695	40,219
North Carolina	11,232	(1)	10,621	12,089	14,216	17,089	19,157	20,381
North Dakota	759	772	1,074	1,193	1,656	1,130	1,338	1,647
Ohio	24,419	20,456	26,097	28,064	32,582	35,273	40,308	35,282
Oklahoma	1,101	724	2,052	2,487	3,543	1,468	6,605	7,787
Oregon	6,761	6,771	6,330	4,020	6,687	5,935	5,829	6,437
Pennsylvania	15,172	13,376	22,406	35,405	42,088	49,100	45,772	47,039
Puerto Rico	413	636	2,044	2,281	3,736	3,588	3,991	3,696
Rhode Island	2,419	2,698	3,176	2,441	3,233	3,092	4,141	4,360
South Carolina	3,343	(1)	4,091	4,182	5,785	10,495	13,954	14,614
South Dakota	1,087	983	1,016	1,223	1,532	1,887	1,744	1,234
Tennessee	4,705	4,674	6,099	6,642	8,336	9,430	13,114	16,659
Texas	5,446	5,641	5,370	4,099	5,652	9,167	13,509	15,447
Utah	3,784	3,857	4,663	5,346	5,209	3,627	3,652	3,333
Vermont	953	1,057	1,778	2,223	2,329	1,984	2,462	2,596
Virgin Islands	232	145	115	82	199	220	184	133
Virginia	4,729	2,802	9,059	13,554	13,054	10,813	11,854	14,138
Washington	14,860	14,184	15,078	14,160	15,895	18,110	22,921	27,063
West Virginia	1,430	1,721	1,829	2,044	2,331	2,107	2,426	2,484
Wisconsin	16,868	21,391	20,514	26,106	44,799	26,847	31,438	30,758
Wyoming	294	267	346	420	453	738	1,034	1,197

[1] Data not reported for this item or insufficient data reported to perform indicated computation.

[2] Less than $500.

Source: Office of Child Support Enforcement.

TABLE 17.—AVERAGE NUMBER OF NON-AFDC CHILD SUPPORT ENFORCEMENT CASES IN WHICH A COLLECTION WAS MADE, SELECTED FISCAL YEARS 1978–90

State	1978	1979	1981	1983	1985	1987	1989	1990
Total	248,590	223,809	325,280	507,031	653,803	934,177	1,246,734	1,361,700
Alabama	110	50	26	221	5,023	11,583	16,602	19,971
Alaska	2,309	2,008	1,967	3,035	3,205	3,184	3,637	3,947
Arizona	(1)	3,478	0	5,525	4,770	4,668	6,740	7,333
Arkansas	764	1,521	2,137	2,803	3,613	5,074	7,241	8,473
California	69,696	54,019	56,803	66,164	64,686	77,448	91,029	96,101
Colorado	1,017	780	2,963	3,647	3,976	4,537	6,054	7,281
Connecticut	(1)	0	0	7,826	9,392	9,884	10,606	11,289
Delaware	3,210	3,104	3,302	3,611	4,395	5,073	6,380	6,770
District of Columbia	93	43	200	478	1,007	1,264	2,653	4,094
Florida	1,200	2,101	1,941	8,002	7,593	25,573	50,995	56,329
Georgia	1,207	1,451	2,018	4,091	5,487	14,883	24,992	30,217
Guam	(1)	0	39	63	65	114	207	378
Hawaii	(1)	0	261	308	352	2,804	6,682	8,103
Idaho	455	314	435	591	1,047	2,529	5,540	6,493
Illinois	196	1,260	3,423	6,433	10,030	14,479	21,781	26,184
Indiana	450	675	1,209	1,784	2,881	12,759	17,990	25,586
Iowa	671	1,460	3,419	4,192	4,913	3,441	10,807	12,400
Kansas	210	320	945	1,449	758	5,260	9,308	11,520
Kentucky	255	1,667	2,076	3,657	3,647	15,549	13,686	17,473
Louisiana	6,866	965	7,706	9,517	10,636	11,695	14,883	16,739
Maine	638	296	196	296	1,496	3,862	5,774	6,425
Maryland	130	0	6,186	27,384	26,154	12,685	15,969	27,339
Massachusetts	(1)	0	0	0	0	26,549	27,950	22,921
Michigan	(1)	0	0	51,304	88,675	126,187	120,969	115,081
Minnesota	2,766	3,866	5,707	10,263	12,615	16,137	23,502	26,712
Mississippi	81	153	248	320	1,319	4,348	6,443	7,917
Missouri	(1)	913	1,754	1,631	5,362	14,676	22,802	26,994
Montana	444	301	329	348	344	800	1,012	1,448
Nebraska	176	181	2,432	4,942	7,874	10,540	13,464	14,748
Nevada	4,026	2,558	4,650	4,084	5,360	3,212	4,085	4,451
New Hampshire	(1)	0	0	5,433	4,939	5,474	5,809	5,260
New Jersey	20,000	13,295	29,130	38,557	45,868	51,706	65,947	66,885
New Mexico	286	875	1,035	1,806	2,249	2,462	4,490	5,360
New York	39,623	37,854	48,370	54,296	63,829	67,460	78,638	83,651
North Carolina	1,715	0	3,190	5,910	10,137	15,323	22,584	27,632
North Dakota	154	149	99	171	266	865	1,427	1,911
Ohio	1,430	1,033	1,857	4,594	10,853	39,114	100,069	101,546
Oklahoma	(1)	184	719	1,269	1,968	4,867	8,635	10,509
Oregon	17,957	28,807	32,472	16,262	19,331	20,620	23,747	25,657
Pennsylvania	49,621	37,877	66,691	92,084	108,498	123,248	140,750	147,885
Puerto Rico	710	178	6,846	17,908	26,873	30,490	35,346	35,295
Rhode Island	57	110	294	1,407	1,969	2,750	3,559	3,725
South Carolina	203	0	472	1,198	2,777	3,165	4,671	4,896
South Dakota	297	254	391	512	502	2,175	3,154	2,739
Tennessee	6,360	7,816	6,251	10,271	12,156	14,957	21,649	28,174
Texas	2,861	1,673	2,744	4,224	8,833	15,079	26,643	37,741
Utah	400	427	489	698	1,068	4,008	5,437	6,738
Vermont	181	194	194	194	393	967	1,459	1,659
Virgin Islands	1	64	188	262	1,288	1,252	1,499	1,247
Virginia	38	36	1,078	1,554	876	19,273	26,638	31,492
Washington	4,822	5,115	6,215	7,422	9,802	13,656	24,331	34,791
West Virginia	130	147	185	186	288	1,953	5,246	8,045
Wisconsin	4,685	4,150	3,876	6,719	20,288	41,953	63,554	55,793
Wyoming	89	87	122	125	77	563	1,669	2,352

[1] Data not reported for this item or insufficient data reported to perform indicated computation.

Source: Office of Child Support Enforcement.

TABLE 18.—NUMBER OF FAMILIES REMOVED FROM AFDC DUE TO CHILD SUPPORT COLLECTIONS, SELECTED FISCAL YEARS 1978–90

State	1978	1979	1981	1983	1985	1987	1989	1990
Total	18,744	27,480	45,631	26,194	33,897	191,715	220,122	239,425
Alabama	1,048	284	135	2,011	324	480	529	611
Alaska	(1)	398	150	220	13	581	0	0
Arizona	118	17	31	10	0	0	0	29
Arkansas	824	215	297	308	109	3,973	3,588	1,781
California	(1)	0	0	0	445	17,607	16,748	15,998
Colorado	1,419	288	172	0	618	1,648	1,087	1,574
Connecticut	(1)	640	209	196	667	594	443	773
Delaware	(1)	128	0	94	54	0	1,106	0
District of Columbia	7	11	53	0	0	0	0	0
Florida	434	356	582	457	305	0	6,294	6,350
Georgia	(1)	272	0	37	1,600	5,427	7,740	8,288
Guam	(1)	0	15	69	0	23	0	0
Hawaii	29	0	27	189	140	161	0	0
Idaho	66	80	480	55	38	723	1,388	1,280
Illinois	718	0	0	546	615	4,923	8,322	8,032
Indiana	(1)	0	5,770	0	154	5,124	3,693	4,495
Iowa	(1)	780	41	23	21	1,620	1,638	1,902
Kansas	1,770	1,197	483	89	194	2,112	2,236	2,184
Kentucky	(1)	0	436	375	257	2,189	2,640	3,659
Louisiana	(1)	796	1,022	732	645	221	237	254
Maine	(1)	0	650	572	197	2,213	2,466	2,374
Maryland	1,848	1,184	970	648	0	2,744	1,117	1,238
Massachusetts	(1)	206	0	370	1,258	6,467	7,863	8,399
Michigan	209	1,417	1,639	1,008	570	489	436	426
Minnesota	582	490	1,146	815	808	5,458	8,417	8,484
Mississippi	47	0	86	0	68	1,494	1,473	1,469
Missouri	(1)	96	952	0	0	[2] 53,355	5,321	6,278
Montana	138	141	82	29	53	41	17	9
Nebraska	96	72	46	3	23	8	8	5
Nevada	(1)	0	106	138	79	115	147	652
New Hampshire	34	0	0	0	28	0	1,079	1,035
New Jersey	2,007	2,218	3,155	2,573	4,386	10,150	9,685	16,013
New Mexico	123	7	66	47	51	90	38	8
New York	(1)	2,050	2,495	3,318	6,105	37,295	83,973	92,750
North Carolina	(1)	244	289	288	145	150	88	61
North Dakota	(1)	1,218	125	578	1,673	1,145	1,236	1,506
Ohio	(1)	243	584	501	226	135	212	213
Oklahoma	859	208	159	169	101	2,749	764	169
Oregon	3,144	3,654	478	243	113	94	3,115	3,477
Pennsylvania	(1)	2,713	0	905	665	7,954	12,777	14,171
Puerto Rico	113	64	260	556	1,032	12	25	42
Rhode Island	(1)	1,810	1,383	0	282	569	583	578
South Carolina	51	0	724	0	1,867	77	16	12
South Dakota	287	136	123	30	36	1,082	1,144	1,220
Tennessee	(1)	0	16,152	4,223	2,730	1,690	2,557	2,195
Texas	1,921	1,697	1,405	2,111	2,851	2,236	1,689	1,540
Utah	329	331	401	0	647	953	942	1,221
Vermont	(1)	0	0	0	0	1,321	1,427	1,429
Virgin Islands	(1)	5	1	0	1	64	212	160
Virginia	167	1,475	524	0	111	1,174	5,070	5,961
Washington	(1)	0	0	0	0	1,388	6,259	7,278
West Virginia	270	250	1,383	932	689	485	620	228
Wisconsin	(1)	0	233	518	903	997	1,509	1,392
Wyoming	86	89	111	208	0	115	148	222

[1] Data not reported for this item or insufficient data reported to perform indicated computation.

[2] Figure is large because of a change in definition and a possible reporting error.

Note: These data are maintained by IV–A agencies, which often results in reporting difficulties for IV–D agencies. Also, 1986 data was reported using a new definition. These data represent IV–A cases closed when a child support payment was received.

Source: Office of Child Support Enforcement.

TABLE 19.—TOTAL NUMBER OF PATERNITIES ESTABLISHED, SELECTED FISCAL YEARS 1978–90

State	1978	1979	1981	1983	1985	1987	1989	1990
Total	110,714	137,645	163,538	208,270	231,838	269,161	337,087	390,650
Alabama	6,160	6,161	4,884	4,833	6,750	6,998	7,839	6,517
Alaska	5	3	73	105	84	364	797	767
Arizona	287	154	542	595	495	1,009	1,327	1,237
Arkansas	3,745	2,586	677	1,489	2,941	5,326	4,453	3,191
California	14,188	19,364	22,791	21,714	23,820	28,570	35,193	41,065
Colorado	1,137	1,046	1,103	1,033	1,426	1,291	1,939	1,864
Connecticut	2,566	3,029	3,769	4,563	4,622	3,908	3,888	4,499
Delaware	242	205	694	1,346	1,120	1,867	1,641	801
District of Columbia	378	386	907	811	583	1,021	2,079	1,579
Florida	6,684	7,078	7,557	10,679	14,452	12,136	13,399	19,534
Georgia	2,527	3,642	5,329	6,102	5,809	14,112	18,198	24,615
Guam	(1)	(1)	297	173	170	122	109	563
Hawaii	726	854	794	1,181	688	1,061	1,295	1,843
Idaho	40	287	79	84	383	384	1,100	1,310
Illinois	1,351	3,025	6,028	7,339	7,035	20,848	29,926	25,496
Indiana	2,052	1,644	1,287	3,036	5,149	3,570	4,943	5,309
Iowa	(1)	575	1,373	922	1,366	1,664	1,980	3,045
Kansas	521	696	1,141	682	325	1,119	2,101	3,644
Kentucky	367	784	2,157	2,986	3,315	3,881	4,498	6,092
Louisiana	1,013	1,304	2,869	3,195	4,235	2,926	4,451	5,525
Maine	(1)	382	339	604	809	951	1,609	1,381
Maryland	6,294	13,307	10,435	8,211	9,263	6,671	9,995	7,538
Massachusetts	1,218	2,096	3,564	3,766	5,208	7,025	6,194	6,339
Michigan	6,567	7,529	10,696	17,374	16,186	18,274	23,142	25,574
Minnesota	1,249	1,786	2,526	2,994	3,265	3,856	6,098	5,661
Mississippi	819	932	1,725	1,797	2,600	1,824	5,773	10,803
Missouri	(1)	(1)	476	17,522	14,423	14,308	11,146	16,242
Montana	68	92	97	37	54	179	388	429
Nebraska	(1)	(1)	268	410	430	710	759	885
Nevada	214	233	395	409	477	531	664	1,033
New Hampshire	42	35	71	30	13	195	518	614
New Jersey	7,503	8,242	11,282	10,616	13,853	13,938	13,182	12,243
New Mexico	170	322	1,258	1,141	709	412	1,571	1,992
New York	16,025	17,503	12,041	15,884	16,595	18,239	18,056	20,492
North Carolina	5,129	6,592	6,728	7,368	9,307	9,916	11,663	14,504
North Dakota	280	293	328	440	530	1,134	820	784
Ohio	2,305	4,808	7,658	7,767	9,314	9,133	11,637	15,482
Oklahoma	32	43	698	1,811	590	512	1,361	1,484
Oregon	1,528	1,521	2,199	2,173	2,189	1,902	3,131	4,081
Pennsylvania	4,811	4,450	7,305	11,906	15,613	15,277	18,921	20,231
Puerto Rico	25	22	38	19	5	6	144	216
Rhode Island	(1)	347	354	451	244	601	673	889
South Carolina	1,055	1,378	1,536	2,552	3,479	3,994	5,243	5,273
South Dakota	104	60	137	172	300	552	504	509
Tennessee	5,077	5,003	5,669	6,592	6,863	7,666	9,647	8,976
Texas	215	202	1,822	1,085	833	684	6,465	12,623
Utah	166	487	1,076	1,546	1,418	1,292	1,801	2,087
Vermont	77	44	245	349	388	1,091	468	533
Virgin Islands	1	4	3	104	146	235	270	160
Virginia	846	1,452	1,995	2,351	1,962	2,667	8,471	13,647
Washington	291	656	981	1,700	2,187	4,066	5,762	6,985
West Virginia	155	156	482	467	223	288	[illegible]	997
Wisconsin	4,440	4,803	4,672	5,688	7,384	8,750	8,695	10,849
Wyoming	19	44	88	66	210	105	340	618

---

[1] Data not reported for this item or insufficient data reported to perform indicated computation.

Source: Office of Child Support Enforcement.

TABLE 20.—TOTAL NUMBER OF SUPPORT OBLIGATIONS ESTABLISHED, SELECTED FISCAL YEARS 1978–90

State	1978	1979	1981	1983	1985	1987	1989	1990
Total	314,584	349,122	414,053	496,294	668,942	812,132	936,114	1,017,532
Alabama	8,545	7,585	5,137	6,766	17,781	12,182	13,999	11,897
Alaska	178	553	955	1,197	1,311	2,376	2,622	2,906
Arizona	([1])	686	2,993	3,069	2,761	2,385	2,164	1,758
Arkansas	6,277	3,382	3,484	3,519	5,698	9,070	6,275	4,855
California	51,752	61,806	63,323	54,598	54,310	49,982	53,292	60,519
Colorado	5,553	4,996	6,560	6,356	5,576	4,034	5,458	4,948
Connecticut	27,858	11,123	12,474	16,272	8,389	6,632	9,268	14,975
Delaware	247	276	1,814	1,709	1,953	3,340	3,644	2,593
District of Columbia	468	416	550	357	701	1,236	2,186	1,281
Florida	13,742	11,560	13,778	18,098	21,037	28,175	22,718	23,479
Georgia	4,443	5,739	7,372	9,551	8,687	14,747	23,207	29,494
Guam	([1])	([1])	169	132	146	152	122	563
Hawaii	2,585	1,748	2,069	3,351	3,234	2,251	3,103	2,491
Idaho	899	9,444	3,965	763	861	1,023	1,745	1,715
Illinois	16,512	11,379	10,933	22,850	20,819	21,278	34,446	34,163
Indiana	3,471	2,314	12,719	12,282	12,307	23,750	21,245	20,970
Iowa	([1])	4,204	10,752	8,490	7,358	8,264	7,263	8,612
Kansas	5,301	2,781	2,600	1,636	1,800	2,235	3,623	3,519
Kentucky	516	1,590	5,718	4,826	6,048	9,284	13,042	16,938
Louisiana	2,094	4,587	7,678	9,483	21,419	16,553	19,567	19,735
Maine	([1])	1,115	3,109	3,374	4,093	5,217	6,381	5,952
Maryland	10,341	8,128	10,100	9,238	27,592	36,902	16,653	19,242
Massachusetts	10,154	9,758	12,414	9,196	11,950	40,477	43,126	34,851
Michigan	6,123	7,572	10,445	15,436	35,416	84,492	138,838	154,348
Minnesota	1,747	4,095	8,268	6,626	10,130	8,372	10,280	15,550
Mississippi	720	730	822	861	3,065	1,921	5,237	8,492
Missouri	([1])	([1])	3,719	12,110	51,918	22,225	18,881	18,577
Montana	139	78	69	486	881	500	773	630
Nebraska	218	([1])	789	875	662	1,484	1,371	1,481
Nevada	1,889	1,579	4,362	3,883	3,339	4,106	2,909	3,066
New Hampshire	162	1,828	219	2,060	387	408	412	1,095
New Jersey	18,408	27,034	24,744	28,481	37,724	32,704	35,854	26,252
New Mexico	1,758	2,826	4,416	4,290	3,044	2,164	4,040	4,975
New York	25,098	28,379	27,987	37,131	43,733	46,108	38,325	51,462
North Carolina	4,282	10,577	11,473	12,584	17,277	16,859	21,222	26,965
North Dakota	589	571	443	528	523	1,162	1,232	1,345
Ohio	6,216	10,248	7,796	8,461	14,080	15,741	32,106	31,587
Oklahoma	624	1,770	3,824	3,747	4,113	3,752	3,592	3,787
Oregon	479	7,660	7,259	6,989	5,830	5,053	8,471	10,794
Pennsylvania	30,243	32,347	34,942	71,041	99,619	130,639	158,442	168,002
Puerto Rico	1,484	1,199	5,372	9,623	12,764	13,413	15,425	15,718
Rhode Island	([1])	2,391	2,835	4,514	2,322	2,607	2,201	3,928
South Carolina	1,065	924	1,272	1,928	4,747	6,117	6,284	5,950
South Dakota	1,735	([1])	338	516	653	1,690	1,238	975
Tennessee	2,603	3,408	4,149	7,307	10,742	16,536	21,858	24,277
Texas	12,171	12,066	11,784	13,523	12,461	32,881	10,197	16,245
Utah	4,520	3,582	4,794	6,251	6,551	5,217	6,152	6,401
Vermont	250	944	1,327	1,436	2,671	2,345	1,376	1,462
Virgin Islands	116	33	138	142	886	529	420	258
Virginia	969	2,407	7,949	5,223	7,594	19,509	35,941	41,581
Washington	10,340	9,546	9,211	10,948	9,961	10,312	14,261	17,175
West Virginia	349	382	728	558	700	843	1,198	1,341
Wisconsin	9,170	9,678	11,544	11,306	18,860	20,445	21,550	25,041
Wyoming	181	98	369	317	458	453	879	1,316

[1] Data not reported for this item or insufficient data reported to perform indicated computation.

Source: Office of Child Support Enforcement.

TABLE 21.—PERCENTAGE OF AFDC ASSISTANCE PAYMENTS RECOVERED THROUGH CHILD SUPPORT COLLECTIONS, SELECTED FISCAL YEARS 1979–90

State	1979	1981	1983	1985	1987	1989	1990
Total	5.8	5.2	6.6	7.3	9.1	10.0	10.3
Alabama	8.5	6.5	10.6	21.0	23.2	30.8	31.7
Alaska	1.5	2.3	5.9	4.6	8.3	12.6	13.7
Arizona	2.0	2.6	2.3	2.5	5.1	3.8	4.4
Arkansas	4.8	5.3	13.3	15.2	17.6	21.0	20.7
California	6.5	4.0	4.6	4.5	6.1	6.0	5.9
Colorado	4.8	5.1	9.4	9.3	9.5	11.4	12.3
Connecticut	6.5	7.6	12.7	10.1	12.2	12.7	9.5
Delaware	4.4	6.2	8.4	14.6	17.3	21.2	20.3
District of Columbia	1.0	1.6	3.0	3.3	3.8	4.7	4.9
Florida	5.5	5.9	4.3	10.0	11.5	11.9	11.6
Georgia	4.3	5.0	6.0	9.8	10.4	12.4	14.3
Guam	5.3	3.0	6.1	6.4	9.1	11.9	10.8
Hawaii	2.9	3.4	5.3	6.6	8.9	7.3	8.8
Idaho	8.9	12.1	17.8	22.6	25.0	33.2	35.7
Illinois	1.5	1.6	2.3	3.2	4.8	5.0	5.6
Indiana	7.2	7.0	12.1	16.1	21.5	23.0	22.4
Iowa	9.0	10.3	13.5	15.0	19.3	19.2	20.1
Kansas	5.0	6.0	8.6	11.6	14.1	13.4	15.9
Kentucky	3.8	2.9	5.0	6.8	8.5	12.0	12.4
Louisiana	5.2	5.7	7.2	8.4	9.1	10.5	11.1
Maine	7.3	8.1	13.3	13.4	20.6	26.1	22.9
Maryland	6.1	7.0	12.4	11.6	11.2	13.0	14.5
Massachusetts	6.6	7.4	13.6	11.3	10.7	12.0	11.8
Michigan	9.0	7.9	8.6	9.7	12.5	13.0	13.9
Minnesota	7.8	8.4	10.0	10.5	12.7	14.2	14.4
Mississippi	2.9	3.7	8.0	7.9	9.4	13.7	16.8
Missouri	2.8	3.4	6.1	9.6	12.0	15.0	17.8
Montana	4.4	5.6	7.7	10.7	8.6	9.9	11.1
Nebraska	5.4	6.4	6.8	10.0	11.5	12.9	13.0
Nevada	6.3	7.1	16.8	14.9	16.4	12.4	12.2
New Hampshire	9.4	8.0	11.2	12.4	15.2	12.4	11.3
New Jersey	5.9	5.9	8.1	9.7	12.5	14.4	14.0
New Mexico	3.4	4.2	6.7	7.3	7.4	9.4	9.2
New York	3.5	3.2	3.9	4.0	5.0	5.6	6.4
North Carolina	5.6	7.5	16.3	15.0	17.4	18.9	18.8
North Dakota	9.6	9.8	13.5	14.7	16.8	17.4	21.0
Ohio	4.8	5.0	5.1	6.2	10.1	9.9	10.0
Oklahoma	1.6	2.5	4.7	7.5	6.4	8.0	9.0
Oregon	9.0	12.0	12.6	13.3	13.0	13.0	13.5
Pennsylvania	4.6	4.9	6.4	8.4	11.0	13.2	12.6
Puerto Rico	.7	1.1	2.9	2.4	2.7	2.3	2.4
Rhode Island	6.1	4.8	6.3	7.0	7.6	8.9	10.4
South Carolina	5.4	5.6	7.9	8.6	13.1	15.9	16.8
South Dakota	6.5	7.1	12.4	12.9	14.4	17.9	17.1
Tennessee	5.0	4.1	6.9	6.5	10.3	14.1	13.7
Texas	5.4	6.3	7.0	6.9	6.2	9.4	9.5
Utah	13.7	16.3	21.6	22.7	19.6	22.1	23.4
Vermont	4.1	5.0	7.2	8.4	11.1	13.4	12.7
Virgin Islands	8.5	5.3	4.7	7.6	8.3	7.9	7.3
Virginia	6.3	5.0	7.0	8.3	9.0	13.5	15.7
Washington	12.5	8.1	10.1	9.8	10.9	14.4	17.1
West Virginia	2.6	3.6	5.8	5.1	7.8	6.1	5.1
Wisconsin	9.5	8.7	8.8	8.8	12.4	15.4	15.5
Wyoming	5.6	6.3	7.1	5.5	8.2	10.0	13.5

Note: Payments to AFDC Unemployed Parent (UP) families have been excluded from the maintenance assistance payments totals in those States having AFDC–UP programs.

Source: Office of Child Support Enforcement.

TABLE 22.—FEDERAL INCOME TAX REFUND OFFSET PROGRAM COLLECTIONS, FISCAL YEARS 1982–90

[In thousands of dollars]

State	1982	1983	1985	1987	1988	1989	1990
Alabama	830	1,555	3,208	5,135	5,735	7,450	8,009
Alaska	114	212	364	891	1,087	995	1,208
Arizona		385	1,062	2,049	2,678	2,592	2,605
Arkansas	679	1,104	1,886	3,770	3,874	4,490	4,669
California	47,279	35,034	34,926	46,287	48,630	50,472	57,624
Colorado	1,318	3,016	2,393	3,020	3,343	4,947	5,604
Connecticut	6,589	4,455	4,224	6,140	7,904	12,132	9,907
Delaware	45	166	1,284	1,319	1,465	1,812	1,966
District of Columbia	587	567	747	779	652	1,202	1,942
Florida	47	1,980	3,938	7,318	13,081	21,294	21,038
Georgia	18	1,526	3,711	7,258	8,833	11,566	13,032
Guam		13	14	44	14	26	13
Hawaii	311	817	846	1,122	1,372	1,511	1,573
Idaho	1,493	1,183	1,204	1,594	1,837	1,959	2,173
Illinois	3,522	4,525	9,019	15,415	15,167	13,887	19,307
Indiana	1,278	4,940	8,975	11,390	13,447	15,642	15,860
Iowa	4,329	5,526	6,784	7,798	8,835	8,990	8,828
Kansas	2,686	2,525	2,905	3,704	4,346	4,947	5,300
Kentucky	2,169	1,165	2,299	3,262	6,314	6,812	6,680
Louisiana	1,427	1,536	2,487	4,722	5,388	5,797	6,582
Maine	664	1,844	2,126	3,377	4,063	4,866	5,383
Maryland	7,912	5,688	6,118	9,646	14,765	17,039	14,343
Massachusetts	2,139	3,325	4,225	5,269	12,137	10,101	11,899
Michigan	20,929	18,250	20,013	25,893	28,296	30,246	29,854
Minnesota	7,040	5,576	5,904	6,762	7,510	7,936	8,096
Mississippi	1,056	1,019	1,976	2,252	2,958	4,147	4,958
Missouri	6,468	4,289	4,849	8,482	10,993	12,438	14,205
Montana	178	431	858	1,209	1,224	1,366	1,301
Nebraska		502	1,205	1,395	2,316	2,598	2,485
Nevada	428	354	389	433	496	630	768
New Hampshire	474	757	662	1,284	1,237	1,137	1,177
New Jersey	9,348	9,458	11,449	14,268	15,195	16,201	16,171
New Mexico	207	533	1,315	2,278	2,434	2,279	2,585
New York	7,446	9,945	11,996	27,991	24,030	23,472	24,763
North Carolina	40	4,235	4,291	7,229	9,352	11,359	11,270
North Dakota	321	352	534	848	792	773	1,302
Ohio	650	2,886	7,229	11,186	14,164	14,346	16,514
Oklahoma	50	703	2,179	2,218	3,328	4,197	4,647
Oregon	7,069	3,782	3,567	4,863	5,080	5,113	5,381
Pennsylvania	2,305	6,112	13,550	17,123	19,880	21,332	24,354
Puerto Rico		2	13	13	52	47	6
Rhode Island	88	838	775	880	1,439	1,401	1,548
South Carolina	138	368	832	1,789	2,197	2,788	3,233
South Dakota	275	374	623	998	1,270	1,465	1,498
Tennessee	42	642	1,592	3,025	6,256	7,110	7,539
Texas		3,906	5,928	11,316	14,129	17,934	19,926
Utah	3,635	2,540	2,765	2,991	3,390	3,730	4,066
Vermont	1,245	611	748	887	1,214	1,154	1,017
Virgin Islands				37	39	34	7
Virginia	1,435	1,674	3,532	6,840	10,383	8,913	9,761
Washington	3,001	4,278	6,201	10,510	11,054	12,537	13,732
West Virginia	259	1,038	1,823	2,013	2,546	2,944	3,066
Wisconsin	8,340	6,266	7,973	10,029	12,723	12,902	13,290
Wyoming	166	222	280	503	600	534	684
Nationwide total	168,068	175,021	229,798	338,853	401,548	443,594	474,748

Source: Office of Child Support Enforcement.

TABLE 23.—ADMINISTRATIVE EXPENDITURES FOR THE CHILD SUPPORT ENFORCEMENT PROGRAM, SELECTED FISCAL YEARS 1979–90

[In thousands of dollars]

State	1979	1981	1983	1985	1987	1988	1989	1990
Alabama	4,633	5,637	9,132	12,786	14,878	17,839	23,101	23,802
Alaska	2,137	2,422	4,016	4,772	5,625	5,751	5,699	6,464
Arizona	2,014	4,659	5,891	5,996	9,096	10,052	13,212	18,744
Arkansas	2,385	3,657	4,539	5,252	5,532	6,870	6,724	9,284
California	75,579	100,807	127,171	131,625	156,472	160,416	176,209	201,823
Colorado	3,861	6,078	7,987	8,827	11,806	13,746	15,160	14,043
Connecticut	5,463	7,833	11,899	14,252	19,682	22,097	24,412	27,135
Delaware	852	2,512	3,299	1,903	4,519	5,924	6,006	6,448
District of Columbia	1,652	3,255	4,968	4,424	5,876	5,745	7,116	7,630
Florida	7,047	10,345	15,718	21,741	41,385	46,094	55,167	66,445
Georgia	3,238	4,777	8,208	11,793	15,200	22,588	29,030	36,927
Guam	108	161	315	296	411	465	641	1,163
Hawaii	1,408	2,708	3,705	4,902	5,157	4,170	5,417	7,598
Idaho	1,063	1,464	2,145	3,016	3,321	4,320	4,822	5,697
Illinois	6,930	14,622	16,320	25,515	35,746	39,467	40,719	52,073
Indiana	4,269	6,147	6,766	8,887	11,601	13,119	14,458	15,643
Iowa	4,239	5,808	5,930	5,805	7,925	8,733	11,043	14,227
Kansas	1,819	3,843	5,220	5,586	8,609	11,037	16,256	16,290
Kentucky	4,027	6,012	7,674	9,387	12,533	15,621	19,460	23,519
Louisiana	7,079	9,401	12,860	16,108	17,587	17,108	17,970	19,408
Maine	1,229	1,863	2,942	3,545	5,986	6,306	7,917	9,351
Maryland	8,177	13,973	16,355	21,739	32,384	33,791	38,281	39,805
Massachusetts	6,710	14,271	19,794	27,515	37,266	37,083	51,432	46,587
Michigan	24,614	30,364	41,365	44,750	55,775	65,825	71,196	82,380
Minnesota	9,273	12,937	17,358	20,249	22,656	27,480	33,242	38,947
Mississippi	1,574	1,965	2,936	3,411	4,590	6,230	10,883	19,551
Missouri	5,355	7,287	9,080	11,330	15,811	20,797	22,814	27,577
Montana	943	1,062	1,128	1,591	1,685	1,865	1,669	3,223
Nebraska	1,378	2,328	3,546	4,729	7,242	8,559	10,312	11,698
Nevada	1,891	3,023	3,437	3,572	4,285	5,537	5,912	7,654
New Hampshire	847	1,019	2,198	2,576	3,292	3,825	5,042	5,558
New Jersey	21,677	28,578	36,082	42,898	54,968	65,428	69,957	77,113
New Mexico	1,437	2,147	3,200	3,310	4,347	5,608	6,258	7,213
New York	61,665	63,658	86,437	101,862	136,254	126,133	119,132	146,468
North Carolina	5,721	8,705	12,293	15,314	18,234	25,951	32,113	37,868
North Dakota	702	1,024	1,246	1,591	2,071	2,256	2,541	2,879
Ohio	11,581	18,307	19,824	24,502	32,001	28,784	64,637	67,891
Oklahoma	2,771	4,896	6,117	6,336	7,384	8,651	11,450	14,073
Oregon	7,475	11,569	11,032	9,826	13,267	13,985	15,164	17,457
Pennsylvania	19,639	29,943	42,962	55,596	60,842	60,040	62,328	70,542
Puerto Rico	862	1,654	3,374	4,543	3,495	4,156	5,789	10,795
Rhode Island	1,079	1,584	2,141	2,456	3,570	4,052	4,413	7,945
South Carolina	1,777	2,215	2,887	6,511	11,150	12,522	15,379	20,127
South Dakota	1,060	1,026	1,198	1,335	2,118	2,358	2,588	2,785
Tennessee	3,046	5,504	7,041	8,175	12,507	12,389	16,482	16,709
Texas	11,733	14,256	15,071	13,960	23,522	29,733	45,563	68,709
Utah	3,094	4,982	6,789	8,609	10,379	10,453	11,307	12,317
Vermont	649	891	958	1,430	1,956	2,116	2,897	2,588
Virginia	4,787	7,038	7,668	8,801	24,399	31,738	990	749
Virgin Islands	483	323	319	715	730	824	31,573	47,061
Washington	10,733	11,826	16,979	22,941	28,293	35,926	47,853	56,189
West Virginia	1,676	2,404	2,550	2,830	4,870	6,740	6,201	7,869
Wisconsin	7,562	11,375	20,662	21,999	24,959	31,512	35,719	41,906
Wyoming	160	278	373	749	696	901	1,552	2,121
Nationwide total	383,163	526,423	691,106	814,165	1,065,942	1,170,714	1,363,209	1,606,065

Source: Office of Child Support Enforcement.

TABLE 24.—TOTAL CHILD SUPPORT COLLECTIONS PER DOLLAR OF TOTAL ADMINISTRATIVE EXPENDITURES, SELECTED FISCAL YEARS 1978–90

State	1978	1979	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
U.S. ratio	3.35	3.48	3.09	2.89	2.93	3.29	3.31	3.45	3.68	3.94	3.85	3.76
Alabama	.75	1.48	.89	1.14	.95	1.11	2.00	2.45	2.69	2.50	2.46	2.78
Alaska	3.19	1.80	2.45	2.68	2.42	2.39	2.26	2.61	3.05	3.46	4.06	4.14
Arizona	.88	3.18	1.88	3.05	1.79	2.18	2.15	1.46	2.21	2.11	1.84	1.49
Arkansas	1.00	1.64	1.33	1.18	1.63	1.63	1.90	2.62	2.94	2.94	3.38	2.80
California	2.15	2.65	2.00	2.19	2.00	2.31	2.32	2.37	2.52	2.75	2.66	2.59
Colorado	1.78	1.04	2.02	2.55	2.15	1.72	2.08	1.89	1.90	1.99	2.21	2.82
Connecticut	4.20	4.22	3.78	3.92	3.30	3.36	3.38	3.49	2.91	2.73	2.76	2.46
Delaware	7.14	6.82	2.76	3.57	2.45	4.64	5.62	2.46	3.07	2.62	3.01	3.13
District of Columbia	.73	.66	.59	.60	.71	.90	1.06	.92	.97	1.21	1.33	1.78
Florida	1.20	1.49	1.64	1.44	1.21	2.43	2.10	2.12	1.98	2.28	2.58	2.66
Georgia	2.22	1.72	1.74	1.34	1.64	1.80	2.23	2.59	3.16	2.88	3.06	3.06
Guam		1.48	.92	1.16	1.24	1.52	1.46	1.39	1.53	1.62	1.28	1.24
Hawaii	1.71	3.66	2.79	2.66	2.72	2.37	2.38	2.26	3.10	3.62	3.62	3.64
Idaho	2.10	2.35	2.24	2.64	2.19	1.86	1.93	3.58	4.06	3.79	3.95	4.02
Illinois	2.10	1.55	.95	1.30	1.96	2.31	2.14	2.40	2.51	2.68	2.77	2.61
Indiana	2.42	2.13	2.01	1.91	3.07	3.29	3.79	4.82	5.22	5.49	5.34	6.15
Iowa	3.49	3.07	3.71	4.30	4.92	5.69	5.92	6.77	6.12	6.36	5.66	4.99
Kansas	3.01	2.19	1.80	2.06	1.90	2.32	2.05	2.15	2.58	2.51	2.00	2.76
Kentucky	1.14	1.21	2.45	2.07	2.57	2.75	2.68	2.52	2.59	2.44	2.63	2.55
Louisiana	1.82	1.79	1.90	2.12	2.00	1.96	2.13	1.99	2.28	2.60	2.85	3.12
Maine	3.40	3.72	3.05	2.84	3.48	3.75	3.98	3.74	3.75	4.01	4.14	3.82
Maryland	2.14	2.55	2.52	3.94	4.72	4.15	3.86	3.77	3.02	3.31	3.36	3.80
Massachusetts	5.12	5.42	3.71	3.85	3.65	3.55	3.57	3.50	3.46	4.09	3.24	3.75
Michigan	9.50	10.09	10.06	6.57	6.62	6.86	7.62	8.33	9.52	8.80	8.58	7.83
Minnesota	2.15	2.30	2.32	2.31	2.59	2.94	2.91	3.02	3.51	3.59	3.65	3.58
Mississippi	.87	1.06	1.28	1.12	1.66	1.77	2.02	2.29	3.36	3.06	2.23	1.56
Missouri	.89	1.09	1.70	2.44	2.00	2.64	3.24	3.89	4.55	4.22	4.45	4.71
Montana	1.58	1.29	1.60	1.67	2.14	2.27	2.46	2.59	3.16	2.97	4.21	2.74
Nebraska	2.10	1.79	4.65	4.54	5.65	5.69	6.32	5.44	5.20	5.02	4.69	4.47
Nevada	1.83	1.84	1.33	1.51	1.62	1.91	2.04	2.10	2.30	1.95	2.22	2.12
New Hampshire	4.05	2.47	2.29	3.12	5.29	5.16	4.96	4.39	5.33	4.93	3.18	3.71
New Jersey	4.16	4.37	3.67	3.96	3.97	4.55	4.67	4.64	4.47	4.12	3.85	3.66
New Mexico	1.17	1.17	1.28	1.30	1.44	1.71	1.90	2.27	1.99	1.76	1.96	2.00
New York	1.75	2.21	2.23	1.95	2.02	2.03	1.96	1.83	1.98	2.36	2.74	2.54
North Carolina	1.50	1.60	1.98	2.00	2.51	2.65	2.94	3.26	3.83	3.32	3.20	3.18
North Dakota	1.83	2.45	1.89	1.91	2.19	2.31	2.29	2.46	2.65	3.14	3.31	3.62
Ohio	2.50	1.97	1.72	1.66	1.76	1.95	3.38	4.41	5.65	10.83	6.07	7.21
Oklahoma	.76	.66	.66	.64	.86	1.36	1.46	1.78	2.22	2.48	2.28	2.29
Oregon	9.48	11.84	9.13	4.13	3.45	3.01	4.05	4.47	4.03	4.27	4.45	4.49
Pennsylvania	9.14	9.51	7.43	7.40	6.65	8.37	6.68	7.78	7.56	8.52	8.97	8.76
Puerto Rico	.92	2.22	1.49	6.06	9.48	24.61	11.95	14.02	18.93	17.60	13.61	7.84
Rhode Island	3.51	3.31	2.38	2.65	3.36	3.36	3.52	3.90	3.31	3.65	3.67	2.52
South Carolina	2.38	1.99	2.40	2.61	2.58	2.49	1.70	2.37	3.01	3.23	3.01	2.60
South Dakota	.99	1.33	1.72	1.81	2.38	2.33	2.36	2.74	2.96	3.50	3.99	3.96
Tennessee	2.49	2.95	1.84	2.72	2.71	3.17	2.88	3.31	3.07	4.09	3.57	4.28
Texas	.74	.70	.82	.84	1.19	1.77	2.17	2.01	2.60	2.81	2.41	2.15
Utah	1.99	2.14	1.95	2.12	2.00	2.01	1.95	2.21	2.39	2.86	2.92	3.09
Vermont	2.24	2.23	2.47	4.01	2.95	2.44	2.58	2.34	2.95	3.31	2.93	3.61
Virgin Islands	.40	.54	1.33	3.03	2.14	3.48	3.27	2.14	4.13	4.16	3.11	4.18
Virginia	.72	1.92	1.41	1.60	1.78	1.74	1.85	1.57	2.41	2.39	3.03	2.35
Washington	2.96	2.52	2.69	2.75	2.45	2.43	2.48	2.42	2.56	2.48	2.66	3.13
West Virginia	.74	.95	.98	.89	1.35	1.52	1.66	1.98	2.00	2.16	2.95	2.75
Wisconsin	3.80	4.53	3.71	2.84	2.71	3.25	3.73	4.78	6.20	6.01	6.18	5.76
Wyoming	3.18	3.25	2.81	2.31	2.72	2.58	1.64	3.27	4.64	4.91	3.50	3.37

Source: Office of Child Support Enforcement.

TABLE 25.—AFDC CHILD SUPPORT COLLECTIONS PER DOLLAR OF TOTAL ADMINISTRATIVE EXPENDITURES, FISCAL YEARS 1980–90

State	1980	1981	1983	1985	1987	1988	1989	1990
Alabama	1.22	0.89	0.85	1.16	1.01	0.89	0.81	0.82
Alaska	.26	.32	.44	.43	.75	.98	1.21	1.26
Arizona	.27	.26	.25	.27	.53	.42	.34	0.33
Arkansas	.75	.73	1.01	1.20	1.59	1.51	1.73	1.27
California	1.05	1.00	1.08	1.17	1.27	1.36	1.29	1.23
Colorado	.68	.74	1.17	1.06	.94	.93	.98	1.19
Connecticut	2.05	2.00	1.73	1.66	1.34	1.21	1.24	1.01
Delaware	1.68	.80	.69	2.02	.92	.80	.88	0.90
District of Columbia	.48	.42	.49	.59	.50	.56	.51	0.54
Florida	1.11	1.19	.66	1.21	.81	.74	.76	0.73
Georgia	1.38	1.56	1.38	1.63	1.66	1.26	1.23	1.24
Guam	.79	.72	.82	.95	.73	.72	.55	0.45
Hawaii	1.41	1.15	1.21	1.05	1.10	1.55	1.14	1.10
Idaho	1.99	1.82	1.77	1.43	1.52	1.30	1.27	1.22
Illinois	1.07	.84	1.16	1.09	1.08	1.04	.92	0.85
Indiana	1.66	1.65	2.61	2.77	2.71	2.69	2.58	2.44
Iowa	2.69	2.62	3.29	4.11	3.51	3.22	2.41	2.01
Kansas	1.35	1.37	1.50	1.75	1.41	1.02	.79	0.93
Kentucky	.82	.72	.82	1.01	.93	1.05	.96	0.95
Louisiana	.86	.79	.75	.81	.90	1.05	1.08	1.07
Maine	2.78	2.54	2.86	2.97	2.60	2.48	2.63	2.26
Maryland	1.27	1.14	1.70	1.30	.85	.90	.88	1.06
Massachusetts	3.12	2.68	2.04	1.68	1.45	1.78	1.35	1.57
Michigan	2.91	2.88	2.36	2.50	2.29	2.00	1.94	1.76
Minnesota	1.36	1.57	1.48	1.52	1.58	1.47	1.27	1.13
Mississippi	1.14	1.16	1.55	1.41	1.65	1.45	1.07	0.74
Missouri	.78	.88	1.27	1.69	1.49	1.29	1.35	1.38
Montana	.83	.98	1.63	2.01	2.00	1.78	2.35	1.36
Nebraska	1.56	1.30	1.04	1.24	.85	.75	.65	0.60
Nevada	.28	.29	.53	.48	.62	.55	.51	0.43
New Hampshire	2.09	2.18	1.21	.98	.83	.74	.60	0.65
New Jersey	1.24	1.12	1.14	1.19	1.07	.99	.88	0.80
New Mexico	.76	.89	.90	1.13	.95	.78	.82	0.77
New York	.75	.75	.79	.78	.75	.88	.99	0.91
North Carolina	1.29	1.35	1.53	1.54	1.82	1.45	1.29	1.22
North Dakota	1.68	1.51	1.61	1.67	1.70	1.85	1.65	1.77
Ohio	1.65	1.67	1.68	1.94	2.09	2.44	1.09	1.13
Oklahoma	.40	.46	.60	1.04	.97	1.00	.87	0.84
Oregon	1.40	1.15	1.15	1.44	1.11	1.10	1.11	1.08
Pennsylvania	1.35	1.25	1.10	1.13	1.28	1.45	1.49	1.37
Puerto Rico	.62	.43	.27	.34	.52	.41	.28	0.16
Rhode Island	2.52	2.29	1.97	2.09	1.70	1.83	1.72	1.28
South Carolina	2.04	2.00	2.08	1.19	1.19	1.01	.93	0.79
South Dakota	1.29	1.19	1.81	1.73	1.44	1.51	1.49	1.33
Tennessee	.92	.64	.79	.72	.97	1.51	1.21	1.37
Texas	.49	.58	.72	1.14	.84	.92	.76	0.58
Utah	1.45	1.63	1.71	1.33	1.13	1.26	1.24	1.22
Vermont	1.87	2.18	2.74	2.21	2.14	2.26	1.78	2.16
Virgin Islands	.28	.47	.44	.29	.33	.35	.23	0.28
Virginia	1.33	1.24	1.53	1.58	.64	.57	.72	0.59
Washington	1.51	1.63	1.56	1.40	1.36	1.23	1.11	1.16
West Virginia	.96	.92	1.30	1.61	1.16	.75	.77	0.52
Wisconsin	2.34	2.90	1.92	2.21	2.30	1.96	1.68	1.42
Wyoming	2.29	1.93	2.12	1.06	2.14	2.09	1.19	1.22
Nationwide total	1.30	1.27	1.27	1.34	1.27	1.27	1.17	1.09

Source: Office of Child Support Enforcement.

TABLE 26.—NON-AFDC CHILD SUPPORT COLLECTIONS PER DOLLAR OF TOTAL ADMINISTRATIVE EXPENDITURES, FISCAL YEARS 1980–90

State	1980	1981	1983	1985	1987	1988	1989	1990
Alabama	0.00	0.00	0.09	0.83	1.68	1.61	1.65	1.96
Alaska	1.82	2.13	1.97	1.83	2.29	2.47	2.86	2.88
Arizona	1.81	1.62	1.55	1.87	1.68	1.69	1.50	1.16
Arkansas	.68	.59	.62	.70	1.35	1.44	1.65	1.53
California	1.10	1.00	.92	1.15	1.26	1.38	1.38	1.36
Colorado	.40	1.28	.98	1.01	.95	1.06	1.23	1.63
Connecticut	1.99	1.78	1.56	1.73	1.56	1.52	1.52	1.45
Delaware	4.71	1.97	1.76	3.60	2.15	1.83	2.12	2.22
District of Columbia	.14	.16	.22	.47	.47	.65	.82	1.24
Florida	.16	.45	.55	.90	1.17	1.55	1.82	1.93
Georgia	.18	.18	.25	.59	1.50	1.62	1.83	1.82
Guam	.01	.20	.42	.51	.80	.90	.74	0.79
Hawaii	2.02	1.63	1.51	1.32	1.99	2.06	2.48	2.54
Idaho	.52	.42	.41	.49	2.55	2.50	2.68	2.80
Illinois	.11	.11	.80	1.04	1.42	1.64	1.85	1.76
Indiana	.26	.36	.46	1.02	2.51	2.80	2.77	3.71
Iowa	.69	1.09	1.64	1.81	2.61	3.14	3.25	2.98
Kansas	.31	.42	.41	.30	1.17	1.50	1.21	1.83
Kentucky	2.26	1.73	1.74	1.67	1.66	1.39	1.67	1.60
Louisiana	1.07	1.11	1.25	1.32	1.38	1.55	1.76	2.04
Maine	.38	.51	.62	1.01	1.15	1.53	1.51	1.57
Maryland	1.28	1.38	3.02	2.56	2.18	2.41	2.48	2.74
Massachusetts	1.16	1.03	1.61	1.89	2.01	2.31	1.89	2.19
Michigan	7.96	7.18	4.26	5.12	7.24	6.80	6.64	6.06
Minnesota	.72	.75	1.11	1.39	1.93	2.12	2.38	2.45
Mississippi	.10	.12	.12	.61	1.71	1.61	1.16	0.82
Missouri	.74	.82	.73	1.55	3.06	2.93	3.11	3.33
Montana	.69	.62	.52	.45	1.17	1.19	1.86	1.37
Nebraska	.30	3.35	4.62	5.08	4.35	4.28	4.04	3.87
Nevada	.98	1.04	1.09	1.55	1.67	1.40	1.71	1.69
New Hampshire	.08	.11	4.08	3.98	4.50	4.18	2.58	3.06
New Jersey	2.90	2.55	2.83	3.47	3.40	3.13	2.97	2.86
New Mexico	.34	.39	.54	.77	1.05	.98	1.14	1.23
New York	1.47	1.47	1.22	1.18	1.23	1.48	1.75	1.62
North Carolina	.28	.62	.98	1.40	2.00	1.87	1.91	1.96
North Dakota	.43	.38	.57	.62	.95	1.29	1.66	1.84
Ohio	.06	.05	.07	1.43	3.56	8.39	4.98	6.08
Oklahoma	.19	.20	.26	.42	1.25	1.47	1.41	1.44
Oregon	8.15	7.98	2.30	2.61	2.92	3.17	3.34	3.41
Pennsylvania	6.70	6.18	5.56	5.55	6.28	7.07	7.48	7.40
Puerto Rico	1.56	1.05	9.21	11.61	18.42	17.19	13.32	7.69
Rhode Island	.10	.09	1.39	1.43	1.61	1.82	1.95	1.24
South Carolina	.39	.40	.50	.51	1.83	2.22	2.08	1.81
South Dakota	.38	.53	.56	.64	1.52	1.99	2.50	2.62
Tennessee	1.55	1.20	1.92	2.16	2.10	2.58	2.36	2.91
Texas	.19	.23	.47	1.03	1.76	1.89	1.65	1.58
Utah	.31	.32	.29	.62	1.26	1.60	1.68	1.87
Vermont	.35	.29	.21	.37	.82	1.05	1.15	1.46
Virgin Islands	.46	.86	1.70	2.97	3.80	3.81	2.88	3.90
Virginia	.08	.17	.24	.27	1.78	1.82	2.31	1.76
Washington	.85	1.06	.89	1.08	1.20	1.24	1.55	1.97
West Virginia	.07	.06	.05	.05	.84	1.41	2.18	2.23
Wisconsin	.65	.81	.80	1.52	3.90	4.06	4.50	4.34
Wyoming	.96	.88	.61	.58	2.50	2.83	2.31	2.16
Nationwide total	1.88	1.82	1.66	1.97	2.41	2.67	2.68	2.67

Source: Office of Child Support Enforcement.

TABLE 27.—CHILD SUPPORT COLLECTIONS PER DOLLAR OF ADMINISTRATIVE EXPENDITURES, FISCAL YEAR 1990

State	Total collections/ total expenditures	AFDC collections/total expenditures	Non-AFDC collections/total expenditures
Alabama	2.78	0.82	1.96
Alaska	4.14	1.26	2.88
Arizona	1.49	0.33	1.16
Arkansas	2.80	1.27	1.53
California	2.59	1.23	1.36
Colorado	2.82	1.19	1.63
Connecticut	2.46	1.01	1.45
Delaware	3.13	0.90	2.22
District of Columbia	1.78	0.54	1.24
Florida	2.66	0.73	1.93
Georgia	3.06	1.24	1.82
Guam	1.24	0.45	0.79
Hawaii	3.64	1.10	2.54
Idaho	4.02	1.22	2.80
Illinois	2.61	0.85	1.76
Indiana	6.15	2.44	3.71
Iowa	4.99	2.01	2.98
Kansas	2.76	0.93	1.83
Kentucky	2.55	0.95	1.60
Louisiana	3.12	1.07	2.04
Maine	3.82	2.26	1.57
Maryland	3.80	1.06	2.74
Massachusetts	3.75	1.57	2.19
Michigan	7.83	1.76	6.06
Minnesota	3.58	1.13	2.45
Mississippi	1.56	0.74	0.82
Missouri	4.71	1.38	3.33
Montana	2.74	1.36	1.37
Nebraska	4.47	0.60	3.87
Nevada	2.12	0.43	1.69
New Hampshire	3.71	0.65	3.06
New Jersey	3.66	0.80	2.86
New Mexico	2.00	0.77	1.23
New York	2.54	0.91	1.62
North Carolina	3.18	1.22	1.96
North Dakota	3.62	1.77	1.84
Ohio	7.21	1.13	6.08
Oklahoma	2.29	0.84	1.44
Oregon	4.49	1.08	3.41
Pennsylvania	8.76	1.37	7.40
Puerto Rico	7.84	0.16	7.69
Rhode Island	2.52	1.28	1.24
South Carolina	2.60	0.79	1.81
South Dakota	3.96	1.33	2.62
Tennessee	4.28	1.37	2.91
Texas	2.15	0.58	1.58
Utah	3.09	1.22	1.87
Vermont	3.61	2.16	1.46
Virgin Islands	4.18	0.28	3.90
Virginia	2.35	0.59	1.76
Washington	3.13	1.16	1.97
West Virginia	2.75	0.52	2.23
Wisconsin	5.76	1.42	4.34
Wyoming	3.37	1.22	2.16
Nationwide total	3.76	1.09	2.67

Source: Office of Child Support Enforcement.

TABLE 28.—INCENTIVE PAYMENTS TO STATES AND LOCALITIES FOR AFDC COLLECTIONS, SELECTED FISCAL YEARS 1979–90 [1]

[In thousands of dollars]

State	1979	1981	1983	1985	1987	1988	1989	1990
Alabama	801	628	1,234	3,024	1,800	2,437	2,872	2,773
Alaska	7	113	245	278	432	1,254	1,002	1,024
Arizona	79	148	198	191	780	910	945	933
Arkansas	247	385	672	749	1,052	1,355	1,582	1,926
California	13,868	9,296	13,102	31,713	23,344	24,670	31,983	37,902
Colorado	407	755	1,337	1,121	1,685	1,783	2,242	2,657
Connecticut	440	2,325	2,977	2,906	3,530	4,237	5,069	4,156
Delaware	23	300	341	462	654	772	688	705
District of Columbia	11	169	267	297	489	477	506	819
Florida	445	2,080	2,108	3,453	4,936	6,740	7,765	7,479
Georgia	384	1,078	1,685	2,312	2,611	3,755	4,032	5,160
Guam	403	2	4	29	30	38	44	64
Hawaii	234	497	524	700	750	766	900	896
Idaho	6	428	471	499	806	881	1,047	1,158
Illinois	414	1,936	2,807	2,767	5,672	7,289	9,437	6,274
Indiana	943	1,502	2,424	2,976	5,830	4,974	7,568	7,880
Iowa	1,456	2,106	3,184	2,804	3,493	5,470	6,750	6,974
Kansas	255	770	1,103	1,100	1,624	1,551	1,701	2,152
Kentucky	552	666	896	1,072	1,550	1,666	2,154	3,418
Louisiana	731	1,181	1,503	1,461	1,808	2,267	2,660	3,037
Maine	61	699	1,250	1,253	1,692	2,407	3,479	3,209
Maryland	662	2,131	3,896	3,089	4,502	5,584	5,670	5,289
Massachusetts	46	5,597	6,046	5,573	7,980	9,194	10,300	10,300
Michigan	12,815	11,550	13,408	14,582	25,336	24,784	26,982	26,488
Minnesota	1,834	2,737	3,826	3,677	5,548	5,835	7,173	7,208
Mississippi	2	59	310	366	853	1,442	1,523	1,717
Missouri	586	888	1,622	1,883	2,796	3,702	5,355	5,703
Montana	20	153	274	363	295	591	646	803
Nebraska	265	419	538	691	842	848	823	1,004
Nevada	74	125	224	154	482	571	590	797
New Hampshire	29	343	374	291	372	405	583	481
New Jersey	4,070	4,681	6,037	5,887	7,526	10,252	11,468	8,251
New Mexico	21	282	434	450	517	672	1,022	1,025
New York	8,787	7,163	10,308	9,498	10,536	12,974	15,147	17,647
North Carolina	1,021	1,724	2,801	2,809	4,182	6,910	6,276	5,861
North Dakota	191	219	284	315	339	486	654	705
Ohio	3,295	4,574	5,010	5,710	8,850	13,788	20,109	10,868
Oklahoma	42	326	547	787	866	1,129	1,234	1,509
Oregon	296	1,845	1,839	1,624	2,168	2,933	3,334	2,932
Pennsylvania	4,701	5,399	6,577	6,788	9,166	11,857	11,613	12,435
Puerto Rico	4	73	127	167	270	436	615	356
Rhode Island	53	505	619	613	1,001	1,427	1,507	1,726
South Carolina	328	354	698	1,015	1,800	2,531	2,727	2,322
South Dakota	45	118	378	227	375	583	771	1,283
Tennessee	493	568	782	716	1,408	1,732	2,547	3,351
Texas	188	1,114	1,609	1,878	2,940	3,999	5,052	6,200
Utah	596	1,238	1,791	730	1,446	1,547	1,633	1,922
Vermont	22	289	392	379	504	625	737	1,121
Virgin Islands	1	23	21	25	30	43	52	43
Virginia	262	1,130	1,728	1,658	2,096	2,318	2,816	3,708
Washington	202	2,817	3,878	3,673	4,504	6,077	8,530	7,009
West Virginia	31	389	492	538	363	1,048	1,110	855
Wisconsin	3,905	4,945	5,417	4,986	9,888	10,215	12,125	11,764
Wyoming	5	69	117	90	170	170	499	380
Nationwide total	66,255	90,911	158,098	144,781	184,519	222,406	265,649	263,660

---

[1] Preliminary data—Incentive payments to States and localities based upon final audited information will be slightly different from what is reported here. The final payments information is unavailable.

Source: Office of Child Support Enforcement.

TABLE 29.—OUT-OF-WEDLOCK BIRTHS AND IV–D PATERNITIES: 1986, 1987, AND 1988

State	Births to unmarried women			IV–D paternities established			Paternities/births (percent)		
	1986	1987	1988	1986	1987	1988	1986	1987	1988
Alabama	15,385	15,955	16,934	6,727	6,998	7,527	43.7	43.9	44.5
Alaska	2,531	2,564	2,627	252	364	602	10.0	14.2	22.9
Arizona	15,598	17,227	18,815	986	1,009	714	6.3	5.9	3.8
Arkansas	8,246	8,498	9,273	7,144	5,326	5,903	86.6	62.7	63.7
California	127,683	136,785	152,607	25,118	28,570	36,001	19.7	20.9	23.6
Colorado	9,927	10,171	10,431	1,451	1,291	1,541	14.6	12.7	14.8
Connecticut	8,504	11,045	11,460	4,579	3,908	3,485	53.8	35.4	30.4
Delaware	2,621	2,742	2,819	1,986	1,867	1,584	75.8	68.1	56.2
District of Columbia	5,800	6,094	6,507	664	1,021	1,055	11.4	16.8	16.2
Florida	44,812	48,200	52,867	14,358	12,136	14,840	32.0	25.2	28.1
Georgia	26,701	28,647	31,348	12,323	14,112	21,321	46.2	49.3	68.0
Hawaii	3,718	3,968	4,222	836	1,061	1,442	22.5	26.7	34.2
Idaho	1,949	2,073	2,216	299	384	590	15.3	18.5	26.6
Illinois	47,843	50,677	54,436	10,820	20,848	26,837	22.6	41.1	49.3
Indiana	16,657	17,260	18,543	3,580	3,570	5,135	21.5	20.7	27.7
Iowa	5,825	6,147	6,736	1,853	1,664	1,893	31.8	27.1	28.1
Kansas	6,568	6,633	7,025	528	1,119	1,505	8.0	16.9	21.4
Kentucky	10,355	10,658	11,206	3,464	3,881	4,306	33.5	36.4	38.4
Louisiana	23,564	23,594	24,752	4,234	2,926	3,460	18.0	12.4	14.0
Maine	3,171	3,338	3,489	570	951	1,774	18.0	28.5	50.9
Maryland	21,198	22,866	24,716	8,167	6,671	9,248	38.5	29.2	37.4
Massachusetts	15,861	17,616	19,559	2,513	7,025	8,103	15.8	39.9	41.4
Michigan	26,620	28,724	30,195	17,737	18,274	20,206	66.6	63.6	66.9
Minnesota	10,721	11,114	12,235	3,646	3,856	4,281	34.0	34.7	35.0
Mississippi	14,228	14,499	15,824	1,964	1,824	2,928	13.8	12.6	18.5
Missouri	16,917	17,823	19,124	10,208	14,308	7,812	60.3	80.3	40.9
Montana	2,262	2,379	2,430	120	179	316	5.3	7.5	13.0
Nebraska	3,788	4,006	4,333	461	710	766	12.2	17.7	17.7
Nevada	2,637	2,740	3,432	503	531	630	19.1	19.4	18.4
New Hampshire	2,213	2,511	2,503	76	195	346	3.4	7.8	13.8
New Jersey	24,887	26,647	28,580	13,731	13,938	13,034	55.2	52.3	45.6
New Mexico	7,629	8,067	8,711	838	412	974	11.0	5.1	11.2
New York	77,535	80,939	84,381	16,929	18,239	17,153	21.8	22.5	20.3
North Carolina	21,323	23,262	25,622	10,014	9,916	11,219	47.0	42.6	43.8
North Dakota	1,398	1,429	1,578	830	1,134	1,022	59.4	79.4	64.8
Ohio	36,917	39,237	42,448	10,057	9,133	8,367	27.2	23.3	19.7
Oklahoma	9,426	9,892	10,600	430	512	1,049	4.6	5.2	9.9
Oregon	8,025	8,672	9,435	2,351	1,902	1,787	29.3	21.9	18.9
Pennsylvania	39,298	41,143	43,919	17,443	15,277	16,127	44.4	37.1	36.7
Rhode Island	2,656	3,064	3,262	98	601	803	3.7	19.6	24.6
South Carolina	14,304	15,333	16,722	2,538	3,994	5,679	17.7	26.1	34.0
South Dakota	2,036	2,225	2,334	426	552	575	20.9	24.8	24.6
Tennessee	16,767	17,897	19,511	7,021	7,666	8,404	41.9	42.8	43.1
Texas	54,240	57,464	59,820	900	684	1,034	1.7	1.2	1.7
Utah	3,575	3,929	4,221	1,103	1,292	1,477	30.9	32.9	35.0
Vermont	1,359	1,459	1,510	688	1,091	1,736	50.6	74.8	115.0
Virginia	19,538	20,562	22,126	2,039	2,667	5,761	10.4	1.3	26.0
Washington	13,745	14,629	16,150	2,018	4,066	4,638	14.7	27.8	28.8
West Virginia	4,530	4,722	4,948	194	288	790	4.3	6.1	16.0
Wisconsin	14,184	14,698	15,528	7,812	8,750	8,654	55.1	59.5	55.8
Wyoming	1,202	1,189	1,229	113	105	79	9.4	8.8	6.4
U.S. total	878,477	933,013	1,005,299	244,740	268,798	306,513	27.9	28.8	30.5

Sources: National Center for Health Statistics. Monthly Vital Statistics Report, vol. 37, no. 3, Supplement, July 12, 1988, page 29, and National Center for Health Statistics, Monthly Vital Statistics Report, vol. 38, no. 3, Supplement, June 29, 1989, page 30. U.S. Department of Health and Human Services, Office of Child Support Enforcement.

LEGISLATIVE CHANGES IN THE 101ST CONGRESS

1. Extension of IRS Intercept for non-AFDC Families

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) permanently extends the Federal provision that allows States to ask the IRS to collect child support arrearages of at least $500 out of income tax refunds otherwise due to noncustodial parents. The minor child restriction is to be eliminated for adults with a current support order who are disabled, as defined under OASDI or SSI. In addition, the offset can be used for spousal support when spousal and child support are included in the same support order.

2. Extension of Interstate Child Support Commission

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) extends the life of the Interstate Child Support Commission from July 1, 1991, to July 1, 1992, and requires it to submit its report no later than May 1, 1992. Also, the provision authorizes the Commission to hire its own staff.

3. Medicaid Transition in Child Support Cases

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) made permanent the requirement that Medicaid benefits continue for 4 months after a family loses AFDC eligibility as a result of collection of child support payments.

LEGISLATIVE CHANGES IN THE 100TH CONGRESS

During the second session of the 100th Congress, The Family Support Act of 1988 (P.L. 100-485) was enacted. It emphasized the duties of parents to work and support their children. The Act emphasized child support enforcement as the first line of defense against welfare dependence. It contained these provisions:

1. Guidelines for Child Support Award Amounts

Judges and other officials are required to use State guidelines for child support unless they are rebutted by a written finding that applying the guidelines would be unjust or inappropriate in a particular case. States must review guidelines for awards every 4 years. Beginning 5 years after enactment, States generally must review and adjust individual case awards every 3 years for AFDC cases. The same applies to other IV-D cases, except review and adjustment must be at the request of a parent.

2. Establishment of Paternity

States are required to meet Federal standards for the establishment of paternity. The standard relates to the percentage obtained by dividing the number of children in the State who are born out of wedlock, are receiving cash benefits or IV-D child support services, and for whom paternity has been established by the number of children who are born out of wedlock and are receiving cash benefits or IV-D child support services. To meet Federal requirements, this percentage in a State must: (1) be at least 50 percent; (2) be at least equal to the average for all States; or (3) have increased by 3 percentage points from fiscal year 1988 to 1991 and by 3 percentage points each year thereafter.

States are mandated to require all parties in a contested paternity case to take a genetic test upon request of any party.

The Federal matching rate for laboratory testing to establish paternity is set at 90 percent.

3. Disregard of Child Support

The child support enforcement disregard authorized under the Deficit Reduction Act of 1984 is clarified so that it applies to a payment made by the noncustodial parent in the month it was due even though it was received in a subsequent month.

4. Requirement for Prompt State Response

The Secretary of Health and Human Services is required to set time limits within which States must accept and respond to requests for assistance in establishing and enforcing support orders as well as time limits within which child support payments collected by the State IV-D agency must be distributed to the families to whom they are owed.

5. Requirement for Automated Tracking and Monitoring System

Every State that does not have a Statewide automated tracking and monitoring system in effect must submit an advance planning document that meets Federal requirements by October 1, 1991. The Secretary must approve each document within 9 months after submission. By October 1, 1995, every State must have an approved system in effect. Federal matching rates of 90 percent for this activity will expire after September 30, 1995.

6. Interstate Enforcement

A Commission on Interstate Child Support is established to hold one or more national conferences on interstate child support enforcement reform, and to report to Congress no later than October 1, 1990 on recommendations for improvements in the system and revisions in the Uniform Reciprocal Enforcement of Support Act.

7. Exclude Interstate Demonstration Grants in Computing Incentive Payments

Amounts spent by States for interstate demonstration projects are excluded from calculating the amount of the States' incentive payments.

8. Use of INTERNET System

The Secretaries of Labor and HHS are required to enter into an agreement to give the Federal Parent Locator Service prompt access to wage and unemployment compensation claims information useful in locating absent parents.

9. Wage Withholding

With respect to IV-D cases, each State must provide for immediate wage withholding in the case of orders that are issued or modified on or after the first day of the 25th month beginning after the date of enactment unless: (1) one of the parties demonstrates, and the court finds, that there is good cause not to require such withholding; or (2) there is a written agreement between both parties providing for an alternative arrangement. Present law requirements for mandatory wage withholding in cases where payments are in arrears apply to orders that are not subject to immediate wage withholding.

States are required to provide for immediate wage withholding for all support orders initially issued on or after January 1, 1994, regardless of whether a parent has applied for IV-D services.

10. Work and Training Demonstration Programs for Noncustodial Parents

The Secretary of HHS is required to grant waivers to up to 5 States to allow them to provide services to noncustodial parents under the JOBS program. No new power is granted to the States to require participation by noncustodial parents.

11. Data Collection and Reporting

The Secretary of HHS is required to collect and maintain State-by-State statistics on paternity determination, location of absent parent for the purpose of establishing a support obligation, enforcement of a child support obligation, and location of absent parent for the purpose of enforcing or modifying an established obligation.

12. Use of Social Security Number

Each State must, in the administration of any law involving the issuance of a birth certificate, require each parent to furnish his or her social security number (SSN), unless the State finds good cause for not requiring the parent to furnish it. The SSN shall not appear on the birth certificate, and the use of the SSN obtained through the birth record is restricted to child support enforcement purposes except under certain circumstances.

13. Notification of Support Collected

Each State is required to inform families receiving AFDC of the amount of support collected on their behalf on a monthly basis, rather than annually as provided under present law. States may provide quarterly notification if the Secretary of HHS determines that monthly reporting imposes an unreasonable administrative burden. This provision is effective 4 years after the date of enactment.

TABLE 30.—CBO FEDERAL BUDGET COST ESTIMATES FOR CHILD SUPPORT ENFORCEMENT AMENDMENTS IN THE FAMILY SUPPORT ACT OF 1988 (PUBLIC LAW 100-485)

[In millions of dollars]

	Fiscal year—				
	1990	1991	1992	1993	Total
Mandate income withholding	—	−25	−55	−90	−170
Mandate child support guidelines	−25	−70	−115	−160	−370
Mandate increases in paternity establishment	—	40	25	15	80
Mandate ADP for most States	2	7	7	7	23
Other	10	9	6	8	33
Total	−13	−39	−132	−220	−404

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) required States to provide child support enforcement services to all families with an absent parent who receives Medicaid and have assigned their support rights to the State, regardless of whether they are receiving AFDC.

LEGISLATIVE CHANGES IN THE 99TH CONGRESS

During the second session of the 99th Congress, Public Law 99-509 was enacted. Titled the Omnibus Budget Reconciliation Act of 1986, the new law included one child support enforcement amendment prohibiting the retroactive modification of child support awards. Under this new requirement, State laws must provide for either parent to apply for modification of an existing order with notice provided to the other parent. No modification is permitted before the date of this notification.

LEGISLATIVE CHANGES IN THE 98TH CONGRESS

In November 1983, the House of Representatives adopted H.R. 4325, the Child Support Enforcement Amendments, which had been developed by the Subcommittee on Public Assistance and Unemployment Compensation and approved by the Committee on Ways and Means. In August 1984, the amendments were signed into law. The new law strengthens the child support enforcement and paternity establishment program. It requires States to implement effective enforcement tools and provides incentives to the States to make available services to both AFDC and non-AFDC families. The main provisions of the Child Support Enforcement Amendments of 1984 (P.L. 98-378) are summarized below:

1. Improved child support enforcement through requiring State laws and procedures.—States are required to enact laws establishing the following procedures with respect to their IV-D cases:

A. Mandatory wage withholding for all families (AFDC and non-AFDC) if support payments are delinquent in an amount equal to 1 month's support. States must also allow absent parents to request withholding at an earlier date.

B. Imposing liens against real and personal property for amounts of overdue support.

C. Withholding of State tax refunds payable to a parent of a child receiving IV–D services, if the parent is delinquent in support payments.

D. Making available information regarding the amount of overdue support owed by an absent parent, to any consumer credit bureau, upon request of such organization.

E. Requiring individuals who have demonstrated a pattern of delinquent payments to post a bond, or give some other guarantee to secure payment of overdue support.

F. Establishing expedited processes within the State judicial system or under administrative procedures for obtaining and enforcing child support orders and, at the option of the State, for determining paternity.

G. Notifying each AFDC recipient at least once each year of the amount of child support collected on behalf of that recipient.

H. Permitting the establishment of paternity until a child's 18th birthday.

I. At the option of the State, providing that child support payments must be made through the agency that administers the State's income withholding system if either the custodial or noncustodial parent requests that they be made in this manner.

2. Federal matching of administrative costs.—The Federal matching share is gradually reduced from 70 percent as follows: 68 percent in fiscal years 1988 and 1989, and 66 percent in fiscal year 1990 and each year thereafter.

3. Federal incentive payments.—The prior incentive formula which gave States 12 percent of their AFDC collections (paid for out of the Federal share of the collections) is replaced with a new formula that is designed to encourage States to develop programs that emphasize collections on behalf of both AFDC and non-AFDC families, and to improve program cost effectiveness. The basic incentive payment will be equal to 6 percent of the State's AFDC collections, and 6 percent of its non-AFDC collections. States may qualify for higher incentive payments, up to a maximum of 10 percent of collections, if their AFDC or non-AFDC collections exceed combined administrative costs for both AFDC and non-AFDC components of the program.

The total dollar amount of incentives paid for non-AFDC families may not exceed the amount of the State's incentive payment for AFDC collections for fiscal years 1986 and 1987. However, thereafter the incentive paid for non-AFDC collections will be capped at an amount equal to 105 percent of the incentive for AFDC collections in fiscal year 1988, 110 percent in fiscal year 1989, and 115 percent in fiscal year 1990 and any fiscal year thereafter.

4. Matching for automated management systems used in income withholding and other procedures.—The Act specifies that the 90 percent Federal matching rate that is currently available to States that elect to establish an automatic data processing and information retrieval system may be used, at the option of the State, for the development and improvement of the income withholding and other procedures required in the new law through the monitoring of child support payments, the maintenance of accurate records regarding the payment of child support, and the provision of prompt notice to appropriate officials with respect to any arrearages that occur. Also, the Act specifies that the 90 percent matching is available to pay for the acquisition of computer hardware.

5. Fees for services to non-AFDC families.—States will be required to charge an application fee for non-AFDC cases not to exceed $25. The amount of the maximum allowable fee may be adjusted periodically by the Secretary to reflect changes in administrative costs. The State may charge the fee against the custodial parent, pay the fee out of State funds, or recover the fee from the noncustodial parent.

In addition, at the option of the State, a late payment fee equal to between 3 and 6 percent of the amount of overdue support may be charged to the noncustodial parents of AFDC and non-AFDC families. The State may not take any action which would have the effect of reducing the amount of support paid to the child and will collect the fee only after the full amount of the support has been paid to the child. The late payment fee provision is effective upon enactment.

6. Continuation of support enforcement for AFDC recipients whose benefits are being terminated.—States must provide that families whose eligibility for AFDC is terminated due to the receipt of (or an increase in) child support payments will be automatically transferred from AFDC to non-AFDC status under the IV–D program, without requiring application for IV–D services or payment of a fee.

7. Special project grants to promote improvement in interstate enforcement.—The Secretary is authorized to make demonstration grants to States which propose to undertake new or innovative methods of support collection in interstate cases. The authorization is $7 million in FY 1985, $12 million in FY 1986, and $15 million in FY 1987 and years thereafter.

8. Periodic review of State programs; modification of penalty.—The Director of the Federal Office of Child Support Enforcement is required to conduct audits at least every 3 years to determine whether the standards and requirements prescribed by law and regulations have been met. Under the penalty provision, a State's AFDC matching funds must be reduced by an amount equal to at least 1 but no more than 2 percent for the first failure to comply substantially with the standards and requirements, at least 2 but no more than 3 percent for the second failure, and at least 3 but no more than 5 percent for the third and any subsequent consecutive failures.

9. Extension of sec. 1115 demonstration authority to the child support program.—The sec. 1115 demonstration authority is expanded to include the child support enforcement program under specified conditions.

10. Child support enforcement for certain children in foster care.—State child support agencies are required to undertake child support collections on behalf of children receiving foster care maintenance payments under title IV–E, if an assignment of rights to support to the State has been secured by the foster care agency. In addition, foster care agencies are required to take steps, where appropriate, to secure an assignment to the State of any rights to support on behalf of a child receiving foster care maintenance payments under the title IV–E foster care program.

11. Collection of spousal support.—Child support enforcement services must include the enforcement of spousal support, but only if a support obligation has been established with respect to the spouse, the child and spouse are living in the same household, and child support is being collected along with spousal support.

12. Modification in content of annual report by the Secretary.—The present annual report information requirements are expanded to include data needed to evaluate State programs.

13. Requirement to publicize the availability of child support services.—States must frequently publicize, through public service announcements, the availability of child support enforcement services, together with information as to the application fee for such services and a telephone number or postal address to be used to obtain additional information.

14. State commissions on child support.—The Governor of each State is required to appoint a State Commission on Child Support. The Commission must include representation from all aspects of the child support system including custodial and non-custodial parents, the IV–D agency, the judiciary, the Governor, the legislature, child welfare and social services agencies, and others.

Each State commission is to examine the functioning of the State child support system with regard to securing support and parental involvement for both AFDC and non-AFDC children, including but not limited to such specific problems as: (1) visitation; (2) establishment of appropriate objective standards for support; (3) enforcement of interstate obligations; and (4) additional Federal and State legislation needed to obtain support for all children.

15. Requirement to include medical support as part of any child support order.—The Secretary of Health and Human Services is required to issue regulations to require State agencies to petition to include medical support as part of any child support order whenever health care coverage is available to the absent parent at a reasonable cost. The regulations must also provide for improved information exchange between the State IV–D agencies and the medicaid agencies with respect to the availability of health insurance coverage.

16. Increased availability of Federal parent locator services to State agencies.—The prior law requirement that the States exhaust all State child support locator resources before they request the assistance of the Federal Parent Locator Service is repealed.

17. Extension of medicaid eligibility when support collection results in termination of AFDC eligibility.—If a family loses AFDC eligibility as the result (wholly or partly) of increased collection of support payments under the IV–D program, the State must continue to provide medicaid benefits for 4 calendar months beginning with the month of ineligibility. (The family must have received AFDC in at least 3 of the 6 months immediately preceding the month of ineligibility.)

18. Guidelines for determining support obligations.—Each State must develop guidelines to be used at the discretion of the court or administrative entity in determining support obligations.

19. Availability of social security numbers for purposes of child support enforcement.—The absent parent's social security number may be disclosed to child support agencies both through the Federal Parent Locator Service and by the IRS.

20. Collection of overdue support from Federal tax refunds.—Prior law requires the Secretary of the Treasury, upon receiving notice from a State child support agency that an individual owes past due support which has been assigned to the State as a condition of AFDC eligibility, to withhold from any tax refunds due that individual an amount equal to any past due support. The act extends this requirement to provide for withholding of refunds on behalf of non-AFDC families, under specified conditions.

21. Wisconsin child support initiative.—The Secretary of HHS is required to grant waivers to the State of Wisconsin to allow it to implement its proposed child support initiative in all or parts of the State as a replacement for the AFDC and child support programs. The State must meet specified conditions and give specific guarantees with respect to the financial well-being of the children involved.

22. Sense of the Congress that State and local governments should focus on the problems of child custody, child support, and related domestic issues.—The act incorporates the language of S. Con. Res. 84 urging State and local governments to focus on the vital issues of child support, child custody, visitation rights, and other related domestic issues that are within the jurisdictions of such governments.

Cost estimates for the major provisions of Public Law 98-378 appear below:

TABLE 31.—CBO FEDERAL BUDGET ESTIMATES FOR CHILD SUPPORT ENFORCEMENT AMENDMENTS OF 1984 (PUBLIC LAW 98-378)

	Fiscal year—				
	1984	1985	1986	1987	Total
Alter incentive payments to States			15	15	30
Reduce Federal matching to 68 percent in fiscal year 1988; 66 percent in fiscal year 1990					0
Require application fees; optional late payment fees		−5	−10	−10	−25
Mandate State enforcement techniques		−15	−25	−25	−65
Require IRS tax intercept for non-AFDC families thru fiscal year 1989		25	20	10	55
Authorize funds for interstate projects		7	12	15	34
Provide Medicaid for 4 months for families losing AFDC due to child support collection through fiscal year 1988	5	25	25	30	85
Other provisions		15	20	10	45
Impact of H.R. 4325 on CSE case levels:					
CSE expenditures		10	30	55	95
Offsetting effects on public assistance		−5	−20	−30	−55
Total	5	57	67	70	199

Note: The cost of disregarding the first $50 of child support payments is shown in the AFDC section.

The Tax Reform Act of 1984 (Public Law 98-369) was also enacted during the 98th Congress and included two tax provisions pertaining to alimony and child support.

Under prior law, alimony was deductible by the payor and includible in the income of the payee. The 1984 law revises the rules relating to the definition of alimony. Generally, only cash payments that will terminate on the death of the payee spouse will qualify as alimony. Alimony payments, if in excess of $10,000 per year, generally must be payable for at least 6 years and must not decline by more than $10,000. The prior law requirement that the payment be based on a legal support obligation has been repealed and payors are now required to furnish to the IRS the social security number of the payee spouse. A $50 penalty for failure to do so will be imposed. The provision is effective for divorce or separation agreements or orders executed after 1984.

The 1984 law also provides that the $1,000 dependency exemption for a child of divorced or separated parents generally will be allocated to the custodial parent unless the custodial parent signs a written declaration that he or she will not claim the exemption for the year. Each parent may claim the medical expenses that he or she pays for the child, for purposes of computing the medical expense deduction. The provision is effective for taxable years beginning after 1984.

Section 9. SSI Program Description

The Supplemental Security Income (SSI) program is a means-tested, federally administered income assistance program authorized by title XVI of the Social Security Act. Established by the 1972 amendments to the Social Security Act (Public Law 92–603) and begun in 1974, SSI provides monthly cash payments in accordance with uniform, nationwide eligibility requirements to needy aged, blind and disabled persons. The SSI program replaced the former Federal grants to the States for old-age assistance, aid to the blind and aid to the permanently disabled. These grants continue in Guam, Puerto Rico and the Virgin Islands. SSI, however, operates in the Northern Mariana Islands.

Basic Eligibility

To qualify for SSI payments, a person must satisfy the program criteria for age, blindness or disability. The aged are defined as persons 65 years and older. The blind are individuals with 20/200 vision or less with the use of a correcting lens in the person's better eye, or those with tunnel vision of 20 degrees or less. Disabled individuals are those unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death or that has lasted, or can be expected to last, for a continuous period of at least 12 months.

Also, a child under age 18 who has an impairment of comparable severity with that of an adult may be considered disabled. On February 20, 1990, the Supreme Court affirmed the Court of Appeals (Third Circuit) decision in *Sullivan* v. *Zebley*. As a result, SSA is required to reevaluate childhood disability claims for SSI benefits which have been denied because the child's functional limitations were not considered in making the decision on the severity of the impairment. Federal regulations that revise the disability evaluation and determination process for SSI claims of disabled children (i.e., implementing the *Zebley* decision) were issued in February 1991.

As explained later, disabled SSI recipients who lose eligibility for regular SSI benefits and for Medicaid because their earnings have exceeded the "substantial gainful activity" earnings test, but who continue to be medically disabled, can continue to receive cash assistance and Medicaid under certain conditions.

A person also must be needy, i.e., have limited income and resources (discussed later) to be eligible for SSI. In addition, to qualify for SSI, a person must (1) be a U.S. citizen or immigrant lawfully admitted for permanent residence, (2) be a resident of the United States or the Northern Mariana Islands, and (3) accept vocational rehabilitation services if offered if SSI eligibility is based on disability or blindness.

Further, since SSI payments are reduced by other income, applicants and recipients must apply for any other money benefits due them. The Social Security Administration works with recipients and helps them get any other benefits for which they are eligible.

Persons who are blind or disabled must accept appropriate vocational rehabilitation services, and those who are disabled and medically determined drug addicts or alcoholics must accept appropriate treatment for their addictions as conditions for SSI eligibility. Additionally, except for children of military personnel, persons outside of the United States for a month are not eligible for SSI. Blind or disabled children of military personnel who accompany their parents to overseas duty stations may be eligible for SSI if they were eligible in the month before they left the United States. (This 1989 Omnibus Budget Reconciliation Act provision does not apply to children of military personnel stationed in Puerto Rico or in other U.S. territories and possessions.)

People who get SSI checks can get Social Security checks, too, if they are eligible for them. However, a person cannot get SSI payments and participate in the AFDC program. If a parent or child is eligible under both programs, the parent can choose whichever best suits the family.

RESTRICTIONS ON SSI ELIGIBILITY OF RESIDENTS OF PUBLIC INSTITUTIONS

An individual who is a resident or an inmate of a public institution is ineligible for SSI unless the institution is a facility approved for Medicaid payments, is receiving such payments on behalf of the person, and these payments represent more than 50 percent of the cost of services provided by the facility to the person. However, SSI payments may be made to persons in publicly operated community residences serving no more than 16 persons. In addition, temporary residents of public emergency shelters can receive SSI payments for up to 6 months in any 9-month period.

The 1987 Budget Reconciliation Act provided for a further exception for those who are in public institutions for medical or psychiatric care. As in the case for temporary care in a nursing home or other medical institution, if a physician certifies that the stay in the medical or psychiatric hospital is not expected to exceed 3 months, the individual can maintain eligibility for SSI benefits based on the full Federal benefit rate for up to 3 months in order to maintain a living arrangement in the community.

INCOME EXCLUSIONS

Under the program, $20 of monthly income from virtually any source (such as Social Security benefits, but *not* need-tested income such as veterans' pensions) is excluded from countable income (total income minus exclusions). In addition, the first $65 of monthly earned income plus one-half of remaining earnings are excluded. Table 1 shows the maximum income that an individual and couple can have and still remain eligible for Federal SSI benefits under the regular Federal SSI benefit standards—taking into account these income exclusions.

SSI law requires that an SSI applicant or recipient apply for all other benefits for which they are eligible. For example, in September 1990, 70 percent of the aged, 36 percent of the disabled, and 38 percent of the blind receiving SSI were also Social Security recipients.

For the blind and disabled only, the cost of an approved plan to achieve self-support is also excluded. SSI recipients who receive benefits on the basis of blindness may also exclude work related expenses. For the disabled, only impairment related work expenses may be excluded. Income received in sheltered workshops and work activity centers is considered earned income and qualifies for earned income exclusions.

The value of any in-kind assistance is counted as income unless such in-kind assistance is specifically excluded by statute. Generally, in-kind assistance provided by or under the auspices of a federally assisted program, or by a State or local government (for example, nutrition, food stamps, housing or social services), will not be counted as income. As described later, if an SSI applicant or recipient is living in the household of another and receiving in-kind support and maintenance from him or her, the SSI benefit standard for such an individual will be reduced by one-third of the Federal SSI benefit standard. By regulation, the Social Security Administration has also provided that the value of any in-kind support and maintenance received (other than in the case of those receiving in-kind assistance by reason of living in another's household), is presumed to be equal to one-third of the Federal SSI benefit standard plus $20. The individual can rebut this presumption. If it is determined that the actual value is less than the one-third amount, the lower actual value will be counted as unearned income.

In legislation enacted in April 1983, in-kind support and maintenance provided by a private nonprofit organization to aged, blind, or disabled individuals must be excluded under the SSI program if the State determines that the assistance is provided on the basis of need. Another exclusion from income is certain types of assistance provided to help meet home energy needs. Assistance provided to an aged, blind, or disabled individual for the purpose of meeting home energy costs either in cash or in kind and which is furnished by a home heating oil or gas supplier or by a utility company is to be excluded. Assistance for home energy costs provided in-kind by a private nonprofit organization is also excluded.

As countable income increases, a recipient's SSI benefit amount decreases. Ineligibility for SSI occurs when countable income equals the Federal benefit standard plus the amount of applicable State supplementation.

A provision in the 1984 Deficit Reduction Act established a limit on the rate that overpayments made to SSI recipients can be recovered. SSI law limits the amount of adjustment or recovery in any month to the lesser of: (1) the amount of the benefit for that month; or (2) an amount equal to 10 percent of the countable income (including the SSI payment) of the individual (or couple) for that month. This limitation does not apply if there is fraud in connection with the overpayment. The recipient may request a different rate at which benefits may be withheld to recover the overpayment.

TABLE 1.—MAXIMUM INCOME FOR ELIGIBILITY FOR FEDERAL SSI BENEFITS, 1991

	Receiving only Social Security		Receiving only wage income	
	Monthly	Annually	Monthly	Annually
Individual	$427	$5,124	$899	$10,788
Couple	630	7,560	1,305	15,660

Source: Office of Research and Statistics, Social Security Administration.

RESOURCES

In 1991, SSI eligibility is restricted to qualified persons who have countable resources not exceeding $2,000, or $3,000 in the case of married couples. The Deficit Reduction Act of 1984 (P.L. 98-369) increased the countable assets limit by $100 a year for an individual and $150 a year for a couple, beginning in calendar year 1985 and each year through calendar year 1989. Prior to January 1, 1985, the assets limit for an individual was $1,500 and $2,250 for a couple. The limit will be $2,000 for an individual and $3,000 for a couple from 1989 on.

In determining resources, a number of items are not included, such as the individual's home; and, within reasonable limits set by the Secretary of Health and Human Services: household goods, personal effects, an automobile, and a burial space for the individual, spouse, and members of the immediate family. Regulations place a limit of $2,000 in equity value on excluded household goods and personal effects and exclude the first $4,500 in current market value of an auto (100 percent of the auto's value if it is used for medical treatment or employment or has been modified for use by a handicapped person or is necessary to perform essential daily activities because of distance, climate or terrain). The value of property which is used in a person's trade, or business, or in the employment of a family member is also excluded. SSI and Social Security retroactive benefit payments may not be considered as a resource for a period of 6 months after the month in which the retroactive benefit is received.

The cash surrender value of life insurance policies if the total face value of all policies on an individual's life is $1,500 or less are not counted toward the $2,000 or $3,000 countable resources limit. The entire cash surrender value of life insurance policies if the total face value of all policies on an individual's life is greater than $1,500 counts toward the resources limit, but may be excludable under one of the other resource provisions.

An individual and spouse may have excluded up to $1,500 each of burial funds. However, the $1,500 maximum amount is reduced by the face value of any excluded life insurance policies and the value of any irrevocable burial contracts, trusts or arrangements. If left to accumulate, interest earned on excluded burial funds and burial spaces is not countable as either income or resources for SSI purposes.

Current law provides that as of July 1, 1988, an individual who gives away or sells any nonexcludable resource for less than fair market value will no longer be subject to a penalty for such a transfer. However, such a transfer may make the individual ineligible for certain Medicaid covered nursing services for up to 30 months. SSA must notify individuals of the penalty and provide information upon request to the States regarding transfers of resources.

The Deficit Reduction Act of 1984 (P.L. 98-369) requires the Internal Revenue Service to furnish the Social Security Administration with certain nonwage information about SSI recipients. The IRS information consists primarily of reports of interest payments submitted to IRS by financial institutions but also includes income from dividends, unemployment compensation, etc. The purpose of the provision was to assist in alerting the Social Security Administration of the potential ownership by SSI recipients of bank accounts in excess of the SSI countable resources limit. In fiscal year 1987, computer matches between IRS tax files and SSI records resulted in 239,000 such matches. Only cases involving IRS reports of interest income of $51 or more were examined. The resulting savings to the SSI program were $64 million. As a result of the Social Security Administration's evaluation of these cases, the tolerance level was lowered to $41 beginning with fiscal year 1988 and 398,000 matches were identified. In fiscal year 1989, the matches totaled 508,000, and SSA again evaluated the tolerance levels. As a result of the newest study, tolerances were adjusted. The resource tolerance remains at $41, and the income tolerance was increased to $501. Also, a special tolerance was developed for cases that had been matched before; if the current year's resources are less than $10 more than the prior year's resource indicators, the IRS report is not examined. All match information is sent to Social Security offices for verification of the information. For fiscal year 1990; there were about 410,000 matches, producing a savings of about $77 million.

Prior to the 1984 Deficit Reduction Act, if in any month a recipient's assets exceeded the asset limit, the individual was ineligible for benefits in that month and the entire amount of the benefit paid for that month was considered an overpayment subject to recovery. Now SSI law provides that in cases where there is an overpayment based on an excess of assets of $50 or less, the recipient is deemed to be without fault for purposes of waiving the overpayment and the overpayment is not recovered unless the Secretary finds that the failure to report the excess was knowing and willful on the part of the recipient.

An individual may receive SSI benefits for a limited time even though he has certain nonliquid property that, if counted, would make him ineligible. These benefits are conditioned upon the disposal of the property, and are subject to recovery as overpayments when the property is sold. The 1987 Budget Reconciliation Act provides, in addition, for the exclusion of real property, for so long as it cannot be sold, because it is jointly owned and sale would cause undue hardship to the joint owner; has legal impediments; or where reasonable efforts to sell it have been unsuccessful.

SSI BENEFITS

Individuals and couples applying for or receiving SSI benefits are determined to be eligible if their countable income does not exceed certain benefit levels.

Regular Federal SSI benefit standard

The regular Federal SSI benefit for an individual for 1991 is $407 a month and $610 for a couple. As is discussed later, most States supplement the regular Federal SSI benefit. The result is a combined regular Federal SSI/State supplemented benefit against which countable income is compared in determining eligibility and benefit amount. However, many States limit their supplementation to certain categories of individuals based on specific indicators of need—especially special housing needs. In September 1990, 394,849 persons, or 8.3 percent of all SSI recipients, were eligible for benefits only because (federally-administered) State supplementation increased the benefit.

The regular Federal SSI benefits are indexed to the Consumer Price Index (CPI) and by the same percentage as Social Security benefits. This occurs through a reference in the SSI law to the Social Security cost-of-living adjustment (COLA) provision. Prior to the Social Security Amendments of 1983 (Public Law 98-21), the SSI and Social Security cost-of-living increases occurred in benefits paid in July. Public Law 98-21 delayed the Social Security and SSI COLA's from July 1983 to January 1984. However, in lieu of a COLA increase in the SSI benefit standard in July 1983, the regular Federal SSI benefit was increased in July 1983 by $20 a month for an individual and $30 a month for a couple. Table 2 shows the regular Federal SSI benefit from the beginning of the SSI program until the present time.

TABLE 2.—FEDERAL SSI BENEFIT LEVELS

[In dollars]

Period	Eligibility status					
	Single		Couple		Medicaid facilities	Essential person
	Own household	Another household	Own household	Another household		
Jan. 1974–June 1974	140.00	93.34	210.00	140.00	25.00	70.00
July 1974–June 1975	146.00	97.34	219.00	146.00	25.00	73.00
July 1975–June 1976	157.70	105.14	236.60	154.74	25.00	78.90
July 1976–June 1977	167.80	111.87	251.80	167.87	25.00	84.00
July 1977–June 1978	177.80	118.54	266.70	177.80	25.00	89.00
July 1978–June 1979	189.40	126.27	284.10	189.40	25.00	94.80
July 1979–June 1980	208.20	138.80	312.30	208.20	25.00	104.20
July 1980–June 1981	238.00	158.67	357.00	238.00	25.00	119.20
July 1981–June 1982	264.70	176.47	397.00	264.67	25.00	132.60

TABLE 2.—FEDERAL SSI BENEFIT LEVELS—Continued

[In dollars]

Period	Eligibility status					
	Single		Couple		Medicaid facilities	Essential person
	Own household	Another household	Own household	Another household		
July 1982–June 1983	284.30	189.54	426.40	284.27	25.00	142.50
July 1983–Dec. 1983	304.30	202.88	456.40	304.27	25.00	152.50
Jan. 1984–Dec. 1984	[1] 314.00	209.34	[1] 472.00	314.67	25.00	157.00
Jan. 1985–Dec. 1985	325.00	216.67	488.00	325.34	25.00	163.00
Jan. 1986–Dec. 1986	336.00	224.00	504.00	336.00	25.00	168.00
Jan. 1987–Dec. 1987	340.00	226.67	510.00	340.00	25.00	170.00
Jan. 1988–Dec. 1988	354.00	236.00	532.00	354.67	25.00	177.00
Jan. 1989–Dec. 1989	368.00	245.34	553.00	368.67	30.00	184.00
Jan. 1990–Dec. 1990	386.00	257.34	579.00	386.00	30.00	193.00
Jan. 1991–Dec. 1991	407.00	271.34	610.00	406.67	30.00	204.00

[1] Cost-of-living adjustments to Federal SSI benefit levels are rounded to the next lower whole dollar beginning with the increase effective January 1984.

Source: Office of Research and Statistics, Social Security Administration.

Living in the household of another

The SSI law provides that if an SSI applicant or recipient is "living in another person's household and receiving support and maintenance in-kind from such person," the Federal SSI benefit applicable to such individual or couple is two-thirds of the regular Federal SSI benefit. As shown in table 2, the Federal SSI benefit in 1991 for those determined to be living in the household of another is $271.34 for an individual and $406.67 for a couple.

Regulations specify the criteria for determining when this reduced benefit applies. It does not apply to an individual who: owns or rents; buys all food separately; eats all meals out; or pays a pro rata share of either the household's food or shelter expenses

In September 1990, 5.7 percent, or about 271,600 SSI recipients, had their benefits determined on the basis of this "one-third reduction" benefit standard. Sixty-five percent of those recipients were receiving benefits on the basis of disability (see table 3).

Of the 27 States that supplement the regular Federal SSI benefit, 10 States provide the same amount of supplementation for those whose Federal SSI benefit amount is determined on the basis of the "one-third reduction." Five States provide a higher State supplementation for such recipients; in eight States the amount of State supplementation is less; three States provide no supplementation for those recipients; and one State's supplementation varies depending upon need.

Medicaid institution/personal needs allowance

When an individual enters a hospital or other medical institution in which a major part of a bill is paid by the Medicaid program, his monthly SSI benefit standard is reduced to $30, beginning with the first full calendar month the individual is in such institution. This Personal Needs Allowance (PNA) is intended to take care of small personal expenses, with the cost of maintenance and medical care being provided through Medicaid. The Federal PNA benefit of $25 was increased to $30 a month on July 1, 1988—the first increase since the SSI program began in 1974. The annual cost-of-living increase for SSI does not apply to the personal needs allowance. The 1987 Budget Reconciliation Act does, however, provide that if a physician certifies that a person's stay in such a medical institution is not likely to exceed 3 months and the person needs to continue to maintain a home to return to, that the SSI benefits will not be reduced and he or she will continue to receive the full SSI benefit for up to 3 months.

Approximately 176,300, or 3.7 percent, of SSI recipients received benefits in September 1990 on the basis of this benefit. For those individuals whose income from non-SSI sources exceeds the $30 benefit standard (including those who previously, when they were not living in a medical institution, were receiving some SSI because their Social Security benefits are less than the regular SSI benefit), Medicaid regulations require States to allow such individuals (and other non-SSI Medicaid eligibles) to retain no less than $30 a month of their income as a "personal needs allowance" when their income is applied, along with Medicaid reimbursement, to pay for their institutional medical care. Approximately 600,000 additional individuals in nursing homes are affected by this requirement.

Sixteen State programs have exercised their option to supplement this Federal SSI benefit. Prior to the 1985 Budget Reconciliation Act, SSI regulations would not allow for Federal administration of the State supplements of these payments. An amendment included in that legislation now requires the Social Security Administration, at the request of a State, to administer such State supplementary payments. As of January 1990, California, District of Columbia, Maine, Massachusetts, Michigan, New Jersey, New York, and Vermont had opted for Federal administration. Approximately 24 States allow some or all of those individuals affected by the Medicaid personal needs allowance regulations to retain more than $30 a month.

Another benefit affecting some persons involves Federal payments to an individual who was transferred to SSI from a former State program of aid to the aged, blind or disabled. These payments are increased by $204 monthly to take into account an "essential person" living in the household. An essential person is generally an ineligible spouse or relative whose needs were considered in determining the requirements of an eligible individual under the former State program but who is not eligible for SSI. Some States have categories of State supplementation similar to the "essential persons" category for individuals transferred from the pre-SSI program.

TABLE 3.—NUMBER AND PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY REASON FOR ELIGIBILITY AND FEDERAL SSI BENEFIT STANDARD/LIVING ARRANGEMENT, SEPTEMBER 1990

Federal benefit standard/living arrangement	Total	Reason for eligibility		
		Aged	Blind	Disabled
Total number	4,764,351	1,451,601	83,673	3,229,077
Total percent	100.0	100.0	100.0	100.0
Regular Federal SSI benefit standard	90.5	90.5	90.6	90.4
Living in the household-of-another Federal SSI benefit standard	5.7	6.1	6.0	5.5
Medicaid institution/personal needs allowance Federal SSI benefit standard	3.7	3.3	3.3	3.9

Source: Office of Research and Statistics, Social Security Administration.

DEEMING OF INCOME AND RESOURCES

The income of an ineligible spouse who lives with an adult SSI applicant or recipient is considered in determining the eligibility and amount of payment to the individual. The income of the parents of a disabled or blind child under the age of 18 is also considered in determining the eligibility and payment for the child. However, effective June 1, 1990, disabled children who are eligible for Medicaid at home under State home care plans, who previously received SSI personal needs allowances while in medical institutions, and who otherwise would be ineligible for SSI because of their parents' income or resources, can receive the $30 monthly personal needs allowance that would be payable if they were institutionalized, without regard to their parents' income and resources. The law also provides that deeming of income and resources shall occur "except to the extent determined by the Secretary to be inequitable under the circumstances".

By regulation, the Secretary of HHS has provided that in determining the amount of the income of the ineligible spouse or parent to be deemed to the SSI applicant or recipient, the needs of the spouse or parent and other children in the household are taken into account. In addition, the SSI earned and unearned income exclusions are applied in determining the amount of income to be deemed to the SSI applicant or recipient. If the combined countable income of an eligible individual and an ineligible spouse does not exceed the SSI benefit standard for an eligible couple in that State (including any State supplementary payment), the SSI applicant or recipient would be eligible to receive an SSI benefit.

For example, in a State with no State supplementation the deeming procedure would work as follows in the case of an ineligible spouse earning $500 per month living with an eligible individual with $180 of Social Security benefits:

Unearned income of eligible individual	$180.00
Less $20 exclusion	−20.00
Countable unearned income	160.00
Earned income of ineligible individual	500.00
Less $65 earned income disregard	−65.00
Less one-half of remaining earnings ($435)	−217.50
Countable earned income	217.50
Plus countable unearned income	160.00
Couple's total countable income	377.50
SSI payment standard for couples	610.00
Less countable income	−377.50
Benefit payable to eligible individual	232.50

Thus the benefit for the eligible individual will be $232.50. Without deeming, the individual would have received $247 [$407−($180 less $20 exclusion)]. The $20 exclusion can only be used once and is first applied to unearned income, which in this example is the $180 of Social Security income.

An individual's resources are deemed to include those of his ineligible spouse (or in the case of a child under the age of 18, those of his parents) with whom he lives. Under the Secretary's regulations, in determining the amount of the spouse's or parents' resources that can be deemed all applicable exclusions are applied. In the case of a child, only the value of the parents' resources that exceeds the applicable limits ($2,000 for a single parent, and $3,000 for two parents) is deemed to the child.

There were 44,900 spouse-to-spouse and 26,100 parent-to-child cases in March 1989 in which deeming reduced the benefit. This does not take into account the number of individuals who were not eligible because of the deeming provision.

In determining the eligibility of aliens applying for SSI, the income and resources of their sponsors are considered. After allowances for the needs of the sponsors and his family, the remainder is deemed available for the support of the alien applicant for a 3-year period after admission as a permanent resident in the United States. This provision does not apply to those who become blind or disabled after admission as a permanent resident, to refugees, and to persons granted political asylum.

STATE SUPPLEMENTATION

State supplementary payments are required by law to maintain income levels of former public assistance recipients transferred to the Federal SSI program. In March 1991, approximately 3,790 recipients were receiving payments based in part or solely because of this provision. States have the option to choose to supplement the Federal SSI benefit standard for both former public assistance recipients and other SSI recipients. At the present time, all but nine States and jurisdictions provide some form of optional State supplementation. Those are: Arkansas, Georgia, Kansas, Mississippi, North Dakota, Northern Mariana Islands, Tennessee, Texas, and West Virginia. States (or local jurisdictions) may elect to administer their supplementary payments themselves or may contract with the Social Security Administration for Federal administration. Seventeen States and the District of Columbia have contracted with the Social Security Administration to administer the State optional supplementation program. Since the SSI program began in 1974, six States have shifted from Federal to State administration of their optional State supplementation program.

State SSI supplement levels over time

Throughout the entire period from July 1975 to January 1991, 23 States have continuously provided supplemental SSI payments to aged individuals living independently, and 21 States continuously supplemented SSI payments to aged couples living independently.

During the period of July 1975 to January 1991, Michigan and Minnesota were the only States which increased supplements faster than inflation for aged individuals living independently (see table 4). Alaska and Oklahoma benefit levels almost kept pace with inflation (5 percent or less decline).

The District of Columbia, South Dakota, Utah, and Wyoming all began supplementing SSI payments to individuals between 1975 and 1980.

Among the States which have supplemented SSI payments for aged couples living independently, only Alaska, Michigan, and Minnesota have kept their supplemental increases equivalent to or higher than inflation (see table 5).

Approximately 42 percent of SSI recipients receive a State supplement. For those SSI recipients, other than those receiving a State supplement because they are living in some type of group living arrangement, the amount of State supplement ranges from $2 a month to $359 a month for an individual. At present, 26 States and the District of Columbia supplement the Federal standard for individuals living independently.

TABLE 4.—STATE SSI SUPPLEMENTS FOR AGED INDIVIDUALS WITHOUT COUNTABLE INCOME LIVING INDEPENDENTLY [1]

State	July 1975	July 1980	Jan. 1985	Jan. 1986	Jan. 1987	Jan. 1988	Jan. 1989	Jan. 1990	Jan. 1991	Percent change (constant dollars) 1975–91 [1]
Alaska [2]	$142	$235	$261	$269	$292	$305	$317	$331	$349	−1
California	101	164	179	197	220	221	234	244	223	−11
Colorado	27	55	58	58	58	58	58	58	45	−33
Connecticut	NA	NA	NA	NA	NA	393	384	366	359	NA
District of Columbia	0	15	15	15	15	15	15	15	15	NA
Hawaii	17	15	5	5	5	5	5	5	5	−88
Idaho	63	74	78	72	73	73	73	73	70	−55
Illinois [3]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maine	10	10	10	10	10	10	10	10	10	−60
Massachusetts	111	137	129	129	129	129	129	129	129	−53
Michigan	12	24	27	28	29	30	30	30	31	+3
Minnesota [4]	31	34	35	35	35	35	35	75	81	+5
Nebraska	67	75	61	62	51	43	38	38	24	−86
Nevada	55	47	36	36	36	36	36	36	36	−74
New Hampshire	12	46	27	27	27	27	27	27	27	−10
New Jersey	24	23	31	31	31	31	31	31	31	−48
New York	61	63	61	72	72	72	86	86	86	−43
Oklahoma	27	79	60	64	64	64	64	64	64	−4
Oregon	17	12	2	2	2	2	2	2	2	−95
Pennsylvania	20	32	32	32	32	32	32	32	32	−36
Rhode Island	31	42	54	56	56	59	61	64	64	−17
South Dakota	0	15	15	15	15	15	15	15	15	NA
Utah	0	10	10	10	9	9	9	6	6	NA
Vermont	29	41	53	56	57	58	60	63	65	−10
Washington [5]	36	43	38	28	28	28	28	28	28	−69
Wisconsin	70	100	100	102	102	103	103	103	103	−41
Wyoming	0	20	20	20	20	20	20	20	20	NA
Median	31	43	36	36	36	36	36	37	36	−53

---

[1] The percentage change in constant dollars was computed by inflating July 1975 to January 1991 by the CPI–U price index. The July 1975 index value is 54.2 and the January 1991 value is 134.6.

[2] 1975 and 1980—less if shelter costs less than $35 monthly.

[3] State decides benefit on a case-by-case basis.

[4] State has two geographic payment levels—Hennepin County and the remainder of Minnesota. Level shown is for Hennepin County, the area with the largest number of SSI recipients.

[5] State has two geographic payment levels—highest levels are shown in table. Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Office of Supplemental Security Income, Social Security Administration, and Committee on Ways and Means staff calculations.

TABLE 5.—STATE SSI SUPPLEMENTS FOR AGED COUPLES WITHOUT COUNTABLE INCOME LIVING INDEPENDENTLY

State	July 1975	July 1980	Jan. 1985	Jan. 1986	Jan. 1987	Jan. 1988	Jan. 1989	Jan. 1990	Jan. 1991	Percent change (constant dollars) 1975–91 [1]
Alabama	$9	0	0	0	0	0	0	0	0	−100
Alaska [2]	183	$338	$371	$383	$427	$444	$462	$484	$510	12
California	251	389	448	485	529	534	563	588	557	−10
Colorado	133	229	278	284	286	292	299	309	293	−11
Connecticut	NA	NA	NA	NA	NA	602	551	525	522	NA
District of Columbia	0	30	30	30	30	30	30	30	30	NA
Hawaii	28	24	9	9	9	9	9	9	9	−87
Idaho	49	80	46	40	44	44	43	45	44	−64
Illinois [3]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maine	15	15	15	15	15	15	15	15	15	−59
Massachusetts	173	214	202	202	202	202	202	202	202	−53
Michigan	18	36	40	42	44	45	45	45	46	2
Minnesota [4]	38	44	66	66	66	66	66	88	132	40
Nebraska	67	114	89	92	78	66	60	65	34	−80
Nevada	106	90	74	74	74	74	74	74	74	−72
New Hampshire	0	42	21	21	21	21	21	21	21	NA
New Jersey	13	12	25	25	25	25	25	25	25	−22
New York	76	79	76	93	93	93	102	102	103	−45
Oklahoma	54	158	120	128	128	128	128	128	128	−4
Oregon	17	10	0	0	0	0	0	0	0	−100
Pennsylvania	30	49	49	49	49	49	49	49	49	−34
Rhode Island	59	79	102	105	106	111	115	120	121	−17
South Dakota	0	15	15	15	15	15	15	15	15	NA
Utah	0	20	20	20	18	18	18	12	12	NA
Vermont	61	76	96	101	104	106	109	115	118	−22
Washington [5]	40	44	37	22	22	22	22	22	22	−78
Wisconsin	105	161	161	164	164	166	166	166	166	−36
Wyoming	0	40	40	40	40	40	40	40	40	NA
Median	57	63	66	66	66	66	60	65	49	−65

[1] The percentage change in constant dollars was computed by inflating July 1975 to January 1991 by the CPI–U price index. The July 1975 index value is 54.2 and the January 1991 value is 134.6.

[2] 1975 and 1980—less if shelter costs less than $35 monthly.

[3] State decides benefit on a case-by-case basis.

[4] State has various geographic payment levels. Level shown is for Hennepin County, the area with the largest number of SSI recipients.

[5] State has two geographic payment levels—highest levels are shown in table. Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Office of Supplemental Security Income, Social Security Administration.

MAXIMUM SSI AND FOOD STAMP BENEFITS FOR INDIVIDUALS LIVING INDEPENDENTLY

Table 6 for individuals living independently and table 7 for couples illustrate the maximum potential payment from Federal SSI, State supplements and food stamps for persons, with no income, by State. These tables assume that the elderly individual or couple receive an excess shelter deduction of $186 and an excess medical cost deduction of $8 in the food stamp program. Approximately 66 percent of the elderly in the food stamp program take a shelter deduction, and it is estimated that approximately 19 percent of the elderly are allowed a deduction that exceeds the excess shelter expense ceiling for nonelderly or non-disabled households ($186 per month). However, since only 12 percent of the elderly claim a medical cost deduction, the $8 average of medical cost deductions over all elderly recipients (both those who claim and those who do not) was used in the table, instead of the average $67 deduction taken by the small minority who claim it. If the higher medical deduction level were used, food stamp benefits shown in the table would be increased by about $20. For those individuals or couples with no shelter deduction, the monthly food stamp and combined benefit amount would be reduced by $55. There is no ceiling on the excess shelter deduction for aged or disabled persons.

TABLE 6.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED INDIVIDUALS LIVING INDEPENDENTLY, JANUARY 1991 [1]

State	Maximum SSI benefit	Food stamp benefit [2]	Combined benefits	
			Monthly	Annual
Alabama	$407	$75	$482	$5,784
Alaska	756	63	819	9,828
Arizona	407	75	482	5,784
Arkansas	407	75	482	5,784
California	630	[3] 0	630	7,560
Colorado	465	58	523	6,276
Connecticut	[4] 766	0	766	9,192
Delaware	407	75	482	5,784
District of Columbia	422	71	493	5,916
Florida	407	75	482	5,784
Georgia	407	75	482	5,784
Hawaii	412	172	584	7,008
Idaho	[5] 477	60	537	6,444
Illinois	[6] NA	NA	NA	NA
Indiana	407	75	482	5,784
Iowa	407	75	482	5,784
Kansas	407	75	482	5,784
Kentucky	407	75	482	5,784
Louisiana	407	75	482	5,784
Maine	[7] 417	89	506	6,072
Maryland	407	75	486	5,784
Massachusetts	536	37	573	6,876
Michigan	438	66	504	6,048

TABLE 6.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED INDIVIDUALS LIVING INDEPENDENTLY, JANUARY 1991 [1]—Continued

State	Maximum SSI benefit	Food stamp benefit [2]	Combined benefits	
			Monthly	Annual
Minnesota	[8] 488	51	539	6,468
Mississippi	407	75	482	5,784
Missouri	407	75	482	5,784
Montana	407	75	482	5,784
Nebraska	431	68	499	5,988
Nevada	443	65	508	6,096
New Hampshire	[9] 434	71	505	6,060
New Jersey	438	66	504	6,048
New Mexico	407	75	482	5,784
New York	493	50	543	6,516
North Carolina	407	75	482	5,784
North Dakota	407	75	482	5,784
Ohio	407	75	482	5,784
Oklahoma	471	56	527	6,324
Oregon	409	75	484	5,808
Pennsylvania	439	66	505	6,060
Rhode Island	471	56	527	6,324
South Carolina	407	75	482	5,784
South Dakota	422	71	493	5,916
Tennessee	407	75	482	5,784
Texas	407	75	482	5,784
Utah	413	74	487	5,844
Vermont	[10] 472	56	528	6,336
Virginia	407	72	482	5,784
Washington	[11] 435	67	502	6,024
West Virginia	407	75	482	5,784
Wisconsin	510	[3] 0	510	6,120
Wyoming	427	69	496	5,952

---

[1] In most States these maximums apply also to blind or disabled SSI recipients who are living in their own households; but some States provide different benefit schedules for each category.

[2] For one-person households, maximum food stamp benefits from Oct. 1990 through Sept. 1991 are $105 in the 48 contiguous States and the District of Columbia, $137 in Alaska (urban areas, benefit levels in rural Alaska are increased by about 50 percent to account for higher food prices in such areas), and $172 in Hawaii. For the 48 contiguous States and D.C., the calculation of benefits assumes: (1) a "standard" deduction of $116 per month; (2) an excess shelter deduction of $186 per month (the maximum allowable for nonelderly, nondisabled households); and (3) an excess medical expense deduction of $8 monthly (estimated from 1988 medical expense information). If smaller excess shelter costs were assumed, food stamp benefits would be smaller. For Alaska and Hawaii, higher deduction levels were used, as provided by law ($522 and $430, respectively, for combined standard and excess shelter allowance).

[3] SSI recipients in California and Wisconsin are ineligible for food stamps. These States provide increased cash aid in lieu of stamps.

[4] Individual budget process.

[5] State disregards $20 of SSI payment in determining the State supplementary payment.

[6] State decides benefits on case-by-case basis.

[7] State disregards $55 monthly of SSi payment in determining the State supplementary payment.

[8] Payment level for Hennepin County. State has two geographic payment levels—one for Hennepin County and the other for the remainder of the State.

[9] State disregards $13 of an individual's income in determining the supplementary payment.

[10] State has two geographic payment levels—highest are shown in table.

[11] Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Table prepared by the Congressional Research Service (CRS) on the basis of data from the Social Security Administration.

TABLE 7.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED COUPLES LIVING INDEPENDENTLY, JANUARY 1991 [1]

State	Maximum SSI benefit	Food stamp benefit [2]	Combined benefits	
			Monthly	Annual
Alabama	$610	$103	$713	$8,556
Alaska	1,120	75	1,195	14,340
Arizona	610	103	713	8,556
Arkansas	610	103	713	8,556
California	1,167	[3] 0	1,167	14,004
Colorado	919	10	929	11,148
Connecticut	[4] 1,132	0	1,132	13,584
Delaware	610	103	713	8,556
District of Columbia	640	94	734	8,808
Florida	610	103	713	8,556
Georgia	610	103	713	8,556
Hawaii	619	261	880	10,560
Idaho	[5] 654	95	749	8,988
Illinois	[6] NA	NA	NA	NA
Indiana	610	103	713	8,556
Iowa	610	103	713	8,556
Kansas	610	103	713	8,556
Kentucky	610	103	713	8,556
Louisiana	610	103	713	8,556
Maine	[7] 625	110	735	8,820
Maryland	610	103	713	8,556
Massachusetts	802	45	847	10,164
Michigan	656	89	745	8,940
Minnesota	[8] 742	63	805	9,660
Mississippi	610	103	713	8,556
Missouri	610	103	713	8,556
Montana	610	103	713	8,556
Nebraska	644	92	736	8,832
Nevada	684	80	764	9,168
New Hampshire	[9] 631	102	733	8,796

TABLE 7.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED COUPLES LIVING INDEPENDENTLY, JANUARY 1991 [1]—Continued

State	Maximum SSI benefit	Food stamp benefit [2]	Combined benefits	
			Monthly	Annual
New Jersey	635	95	730	8,760
New Mexico	610	103	713	8,556
New York	713	72	785	9,420
North Carolina	610	103	713	8,556
North Dakota	610	103	713	8,556
Ohio	610	103	713	8,556
Oklahoma	738	64	802	9,624
Oregon	610	103	713	8,556
Pennsylvania	659	88	747	8,964
Rhode Island	731	66	797	9,564
South Carolina	610	103	713	8,556
South Dakota	625	98	723	8,676
Tennessee	610	103	713	8,556
Texas	610	103	713	8,556
Utah	622	99	721	8,652
Vermont	[10] 728	67	795	9,540
Virginia	610	103	713	8,556
Washington	[11] 632	96	728	8,736
West Virginia	610	103	713	8,556
Wisconsin	776	[3] 0	776	9,312
Wyoming	650	91	741	8,892

[1] In most States these maximums apply also to blind or disabled SSI recipients who are living in their own households; but some States provide different benefit schedules for each category.

[2] For two-person households, maximum food stamp benefits from Oct. 1990 through Sept. 1991 are $193 in the 48 contiguous States and the District of Columbia, $252 in Alaska (urban areas, benefit levels for rural Alaska are about 50 percent higher to account for high food prices in such areas), and $316 in Hawaii. For the 48 contiguous States and D.C., the calculation of benefits assumes: (1) a "standard" deduction of $116 per month, (2) an excess shelter deduction of $186 per month (the maximum allowable for nonelderly, nondisabled households); and (3) an excess medical expense deduction of $8 monthly (estimated from 1988 medical expense information). If smaller excess shelter costs were assumed, food stamp benefits would be smaller. For Alaska and Hawaii, higher deduction levels were used, as provided by law ($522 and $430, respectively, for combined standard and excess shelter allowance).

[3] SSI recipients in California and Wisconsin are ineligible for food stamps. These States provide increased cash aid in lieu of stamps.

[4] Individual budget process.

[5] State disregards $20 monthly of SSI income in determining the State supplementary payment amounts.

[6] State decides benefits on case-by-case basis.

[7] State disregards $40 monthly of SSI income in determining State supplementary payment amounts.

[8] Payment level for Hennepin County. State has two geographic payment levels—one for Hennepin County and one for the remainder of the State.

[9] State disregards $20 monthly of a couple's SSI income in determining supplementary payment amounts.

[10] State has two geographic payment levels—highest levels are shown in table.

[11] Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Table prepared by the Congressional Research Service (CRS) on the basis of data from the Social Security Administration.

State supplementation for special housing needs

A significant number of the aged, disabled and blind population receiving SSI cannot live alone because of mental or physical limitations and have a need for housing which involves services beyond room and board. These services often include supervision for daily living and protective services for the mentally retarded, chronically mentally ill, or the frail or confused elderly. Such nonmedical supervised and/or group living arrangements generally cost more than the Federal SSI benefit needs standard of $407 a month and often more than the combined Federal and SSI State supplementation for those classified as living independently.

All but 7 of the 50 States and the District of Columbia have Federal or State administered State supplementation which is specifically directed at covering the additional cost of providing housing in a protective, supervised, or group living arrangement.

These living arrangements are identified by a variety of terms including: adult foster care homes; domiciliary care homes; congregate care; group homes for the mentally retarded and a variety of other terms. The amount of supplementation by the State also varies a great deal. For example, in the State of Maryland under a State-administered supplementation program, a "specialized and intensive supervision" group living facility has a State supplementation of $709 a month in addition to the Federal benefit level of $407. The total Federal and State SSI payment in a month is $1,116. In other States the State supplementation is less than $2 a month for those who need little supervision and care. However, in some States, the cost of supervised group living care is also partially met by direct State funding of the staff. In a number of States, the State makes payments for nonmedical group care directly to private residential facilities based on a rate negotiated by the State with each facility. In such cases, there is often a "personal needs allowance" payment made directly to or on behalf of the residents of the facility.

COMPARISON OF SSI PAYMENT LEVELS TO POVERTY THRESHOLDS

Table 8 compares the Federal SSI benefit for a single individual to the Bureau of the Census poverty threshold. Both the poverty threshold and the benefit level are indexed to the Consumer Price Index. (The percentage increase for the poverty threshold and the SSI benefit increase varies slightly because of a difference in the method of calculation.) As a result of Public Law 98-21, the SSI benefit levels were increased by $20 per month for individuals and $30 per month for couples in July 1983. They were further increased by 3.5 percent in January 1984. This explains why SSI benefits, in relation to the poverty level, increased to approximately 75 percent in 1984 and 1985 compared to 71 percent in the 1975 to 1982 period.

For individuals receiving unearned income such as Social Security, the amount of income is $240 per year more than the SSI benefit. Because the $240 amount is not indexed, the percent of poverty is slightly lower in 1991 compared to 1975 despite the SSI benefit increases.

Table 9 presents the same information for a couple. The SSI benefit for a couple is approximately 88 percent of the poverty threshold.

TABLE 8.—COMPARISON OF COMBINED BENEFITS TO POVERTY THRESHOLDS FOR ELIGIBLE INDIVIDUALS RECEIVING SSI; SSI AND SOCIAL SECURITY; AND SSI, SOCIAL SECURITY AND FOOD STAMPS FOR SELECTED YEARS: 1975 TO 1991

	Calendar year—							
	1975	1980	1984	1986	1988	1989	1990	1991
Poverty threshold	2,572	3,941	4,980	5,255	5,672	5,947	6,268	[1] 6,575
Federal SSI benefits:								
Dollars per year	1,822	2,677	3,768	4,032	4,248	4,416	4,632	4,884
Percent of poverty	70.8	67.9	75.7	76.7	74.9	74.3	73.9	74.2
Federal SSI and Social Security:								
Dollars per year	2,062	2,917	4,008	4,272	4,488	4,656	4,872	5,124
Percent of poverty	80.2	74.0	80.5	81.3	79.1	78.3	77.7	77.9
Federal SSI, Social Security, and food stamps: [2]								
Dollars per year	2,350	3,345	4,294	4,488	4,848	5,016	5,318	5,580
Percent of poverty	91.4	84.9	86.2	85.4	85.5	84.3	84.8	84.9

[1] Projected on basis of CBO projected increases in the consumer price index.

[2] In computing the food stamp benefit for 1975, average deductions among all elderly households are assumed. For later years, the applicable standarddeduction plus average shelter and medical deductions among all elderly households is assumed.

Source: Congressional Research Service.

TABLE 9.—COMPARISON OF COMBINED BENEFITS TO POVERTY THRESHOLDS FOR ELIGIBLE COUPLES RECEIVING SSI; SSI AND SOCIAL SECURITY; AND SSI, SOCIAL SECURITY AND FOOD STAMPS FOR SELECTED YEARS: 1975 TO 1991

	Calendar year—							
	1975	1980	1984	1986	1988	1989	1990	1991
Poverty threshold	3,232	4,954	6,280	6,628	7,156	7,503	7,906	[1] 8,293
Federal SSI benefits:								
Dollars per year	2,734	4,016	5,664	6,048	6,384	6,636	6,948	7,320
Percent of poverty	84.6	81.1	90.2	91.2	89.2	88.4	87.9	88.3
Federal SSI and Social Security:								
Dollars per year	2,974	4,256	5,904	6,288	6,624	6,876	7,188	7,560
Percent of poverty	92.0	85.9	94.0	94.9	92.6	91.6	90.9	91.2
Federal SSI, Social Security, and food stamps: [2]								
Dollars per year	3,430	4,906	6,393	6,696	7,200	7,476	7,935	8,340
Percent of poverty	106.1	99.0	101.8	101.0	100.6	99.6	100.4	100.6

[1] Projected on basis of CBO projected increases in the consumer price index.

[2] In computing the food stamp benefit for 1975, average deductions among all elderly households are assumed. For later years, the applicable standard deduction plus average shelter and medical deductions among all elderly households is assumed.

Source: Congressional Research Service.

CHARACTERISTICS OF THE SSI POPULATION

As shown in table 11, in September 1990, 4.764 million persons received federally administered SSI payments. Of these, 1.452 million received federally administered payments on the basis of being aged, 3.229 million on the basis of being disabled, and 83,673 on the basis of blindness. However, approximately 601,000 of those receiving benefits on the basis of disability or blindness were over the age of 65. Table 11 also indicates that approximately 2.7 million of those receiving federally administered SSI payments only receive Federal SSI payments, 1.7 million receive a combination of federally financed and State financed payments, and 395,000 receive State financed supplementation only.

Table 12 shows the trends in the numbers of persons receiving federally administered SSI payments from December 1975 through September 1990, both by reason for eligibility and by age categories. There was a steady decline in the number of SSI recipients from 1975 until 1983. However, in the last 7 years the number of SSI recipients has increased from about 3.9 million to nearly 4.8 million.

Characteristics of adult SSI recipients receiving benefits on the basis of disability or blindness

Major disabling diagnosis.—As shown on table 10, of the SSI disabled ages 18–64, 26.9 percent were eligible on the basis of mental retardation; and 24.1 percent on the basis of other mental disorders. Therefore, over one-half of all SSI disabled recipients are eligible on the basis of a mental disability. The next three largest categories are: diseases of the nervous system and sense organs—12.7 percent; diseases of the circulatory system—8.3 percent; and diseases of musculoskeletal and connective tissues—7.3 percent. In comparison, only 25 percent of the Social Security disabled workers are eligible on the basis of a mental disorder; 20 percent of recipient's major disabling diagnosis was circulatory disorders; and musculoskeletal impairments account for 18 percent. Related to the nature of the impairments of the SSI disabled is the fact that in December 1988, 847,737 or 31 percent of the adult disabled or blind receiving SSI benefits had a representative payee. Representative payees are individuals, agencies or institutions selected by the Social Security Administration to receive and use SSI payments on behalf of the SSI recipient when it has been found necessary by reason of the mental or physical limitations of the recipient.

Age.—When a person who is receiving SSI on the basis of blindness or disability becomes age 65, the Social Security Administration does not convert the individual to eligibility on the basis of age. As shown in table 13, 19.9 percent of the SSI adult population receiving benefits on the basis of disability are age 65 or over (29.4 percent of the blind were age 65 or over).

Sex.—In September 1990, 57.7 percent of those receiving SSI benefits on the basis of disability and 57.3 percent on the basis of blindness were women (table 14).

Race.—In September 1990, 53.8 percent of those receiving SSI on the basis of disability were white; 26.8 percent were black; 7.1 percent were other races; and in 12.4 percent of the cases, race was not reported (table 14).

Other income.—As shown in table 15, 36.1 percent of the disabled and 38.3 percent of the blind received Social Security benefits. Table 16 shows the number of SSI recipients with other sources of unearned income.

Of the disabled receiving SSI, 6.0 percent had earned income in September 1990. Of the blind, 7.5 percent had earned income in that month (table 15).

Characteristics of SSI recipients receiving benefits on the basis of age

Age.—As shown in table 13, of those SSI recipients receiving benefits on the basis of age, i.e., age 65 or older, 39.3 percent were 80 years of age or older.

Sex.—As shown in table 14, 74.9 percent of those receiving benefits on the basis of age were women.

Race.—As shown in table 14, 43.6 percent of those receiving SSI on the basis of age were white; 18.6 percent were black; 13.8 percent were other races; and in 24.1 percent of the cases, race was not reported.

Other income.—As shown in table 15, 69.5 percent of the SSI recipients receiving benefits on the basis of age also received Social Security benefits. Only 1.8 percent had earned income.

Characteristics of disabled or blind children receiving SSI

In a study completed in 1979, it was found that 15 percent of all SSI children were in foster care and under the protective custody of State welfare departments or other social welfare agencies or institutions. For over one-half of these children their main disability was mental retardation. They had lived away from their parents an average of 7.5 years and had little or no contact with their parents. In two-thirds of the cases, the children had been placed voluntarily in foster care by their parents.

For those SSI children not in foster care, 42 percent lived in households that had received AFDC or State or local general assistance during the previous year. For the disabled children not in foster care receiving SSI benefits, mental retardation was the main disability in 27 percent of the cases. Other disabling conditions for this group of children included: other diseases of the nervous system (epilepsy, muscular dystrophy, etc.) 15 percent; other mental conditions (schizophrenia, psychosis, etc.) 15 percent; and congenital anomalies (spina bifida, Down's syndrome and hydrocephalus, etc.) 11 percent.

TABLE 10.—DISABILITY DIAGNOSIS OF SSI, SECTION 1619, AND SOCIAL SECURITY DISABILITY RECIPIENTS: 1987

[Percentage distribution by diagnostic group]

Diagnostic group	Supplemental security income—SSI			Social Security disability insurance—SSDI			
	All SSI disabled 18–64 yrs.[1]	SSI sec. 1619(a) participants[2]	SSI sec. 1619(b) participants[2]	All SSDI disabled workers[3]	SSDI disabled workers under age 40[3]	SSDI disabled widows and widowers[4]	SSDI disabled adult children[4]
Individuals	1,723,900	17,813	15,641	2,774,200	496,900	105,300	567,000
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious and parasitic diseases	.8	1.0	1.1	1.0	.7	1.6	.7
Neoplasms	1.9	1.2	2.3	3.5	2.4	2.9	.5
Endocrine, nutritional, and metabolic disorders	4.3	1.4	2.4	3.7	2.8	9.9	.5
Diseases of blood and blood-forming organs	.7	.5	.6	.2	.6	0	.5
Mental disorders (other than mental retardation)	24.1	30.4	36.7	21.4	37.6	17.9	12.6
Mental retardation	26.9	41.6	24.6	4.7	12.7	6.2	63.3
Diseases of:							
Nervous system and sense organs	12.7	14.0	16.2	11.0	14.9	12.4	13.7
Circulatory system	8.3	1.7	2.9	20.2	3.5	20.1	.6
Respiratory system	3.1	.6	.8	4.8	.7	10.4	.3
Digestive system	1.1	.2	.7	1.6	1.2	1.3	.2
Genitourinary system	1.0	1.2	1.6	1.1	1.7	.6	.4
Skin and subcutaneous tissue	.2			.4	.3	.5	.1
Musculoskeletal system	7.3	2.3	3.8	18.2	7.7	13.7	1.1
Congenital anomalies	2.5	1.4	1.2	1.0	1.1	.6	3.3
Injuries	3.2	2.0	4.3	6.7	11.5	1.4	1.7
Other	1.9	.4	.8	.5	.6	.7	.6

---

[1] For an estimated 1,306,500, diagnosis was available from the 1-percent sample file. This figure is from a total of 1,723,900 disabled adults aged 18–64 receiving federally administered SSI payments in December, 1987. The 265,300 disabled adults who were transferred from the pre-SSI State APTD programs are not included.

[2] Information on diagnosis of section 1619 participants is available from SSI files only for persons applying since 1982. These data are for September 1988. Percentages shown are based on diagnosis information of 8,706 1619(a) participants and 7,480 1619(b) participants.

[3] Based on 1-percent sample of those 2,560,600 individuals for whom diagnosis information was available of the 2,774,200 disabled workers in current pay status in December, 1987.

[4] Based on 1-percent sample of those 87,600 individuals for whom diagnosis information was available of the 105,300 disabled adult children in current pay status in December, 1987.

[5] Based on 1-percent sample of those 567,000 individuals for whom diagnosis information was available of the 221,200 disabled widows and widowers in current pay status in December, 1987.

Source: Social Security Administration.

TABLE 11.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS AND AVERAGE MONTHLY AMOUNT, BY REASON FOR ELIGIBILITY AND TYPE OF PAYMENT, SEPTEMBER 1990

Type of payment	Total	Aged	Blind	Disabled
	Number of persons			
Total	4,764,351	1,451,601	[1] 83,673	[2] 3,229,077
Federal SSI payments	4,369,502	1,257,969	74,900	3,036,631
Federal SSI payments only	2,719,231	806,221	42,929	1,870,081
Federal SSI and State supplementation	1,650,271	451,748	31,971	1,166,552
State supplementation	2,045,120	645,380	40,744	1,358,996
State supplementation only	394,849	193,632	8,773	192,444
	Average monthly amount			
Total	$290.41	$210.30	$335.04	$325.27
Federal SSI payments	253.11	171.66	271.40	286.41
State supplementation	135.75	138.41	189.10	132.89

[1] Includes approximately 22,200 persons aged 65 or over.

[2] Includes approximately 579,800 persons aged 65 or over.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 12.—SSI: NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS, BY REASON FOR ELIGIBILITY AND AGE: DECEMBER 1975 AND 1978, SEPTEMBER 1983, 1986, 1987, 1988, 1989, AND 1990

[In thousands]

Reason for eligibility and by age categories	Dec. 1975	Dec. 1978	Sept. 1983	Sept. 1986	Sept. 1987	Sept. 1988	Sept. 1989	Sept. 1990
Total	4,314	4,217	3,898	4,232	4,351	4,434	4,570	4,764
Reason for eligibility:								
Aged	2,307	1,968	1,528	1,476	1,455	1,434	1,439	1,452
Blind	74	77	79	83	83	83	83	84
Under 18	3	5	6	7	7	7	7	7
18 to 21	4	3	5	5	4	4	4	4
22 to 64	46	43	45	48	49	49	49	50
65 and over	22	25	23	23	23	22	22	22
Disabled	1,933	2,172	2,292	2,673	2,813	2,917	3,048	3,229
Under 18	104	161	191	231	243	247	256	287
18 to 21	90	111	122	138	136	136	139	143
22 to 64	1,559	1,581	1,517	1,787	1,902	1,987	2,091	2,219
65 or over	179	319	462	517	533	548	563	579
Age:								
Under 18	107	166	197	238	250	254	263	294
18 to 21	93	115	127	143	141	140	143	147
22 to 64	1,605	1,624	1,562	1,835	1,951	2,036	2,140	2,269
65 and over	2,508	2,312	2,013	2,016	2,010	2,003	2,023	2,051

Source: Office of Research and Statistics, Social Security Administration.

TABLE 13.—NUMBER AND PERCENTAGE DISTRIBUTION OF ALL ADULTS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY REASON FOR ELIGIBILITY AND AGE, SEPTEMBER 1990

Age	Total	Aged	Blind	Disabled
Total number	4,439,850	1,451,601	75,580	2,912,669
Total percent	100.0	100.0	100.0	100.0
18 to 21	2.6		4.0	3.9
22 to 29	8.9		13.8	13.2
30 to 39	11.9		16.5	17.7
40 to 49	10.3		12.5	15.3
50 to 59	12.2		14.3	18.3
60 to 64	7.8		9.5	11.7
65 to 69	12.2	19.4	8.7	8.7
70 to 74	10.7	20.9	6.6	5.7
75 to 79	9.6	20.4	5.5	4.3
80 or older	13.8	39.3	8.6	1.2

Source: Office of Research and Statistics, Social Security Administration.

TABLE 14.—NUMBER AND PERCENTAGE DISTRIBUTION OF ALL PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY REASON FOR ELIGIBILITY, RACE, AND SEX, SEPTEMBER 1990

Race and sex	Total	Aged	Blind	Disabled
Total number	4,764,351	1,451,601	83,673	3,229,077
Total percent	100.0	100.0	100.0	100.0
Race:				
White	50.6	43.6	52.6	53.8
Black	24.2	18.6	25.2	26.8
Other	9.1	13.8	9.2	7.1
Not reported	16.0	24.1	13.0	12.4
Sex and race:				
Men	37.1	25.1	42.7	42.3
White	19.3	9.9	23.8	23.5
Black	8.8	3.8	10.1	11.0
Other	3.8	4.9	4.1	3.3
Not reported	5.2	6.5	4.6	4.6
Women	62.9	74.9	57.3	57.7
White	31.3	33.7	28.8	30.3
Black	15.5	14.8	15.1	15.8
Other	5.4	8.9	5.1	3.8
Not reported	10.8	17.5	8.3	7.8

Source: Office of Research and Statistics, Social Security Administration.

In summary, the trends in the nature of the SSI population show the following:

—A steady decline in the number of persons receiving SSI benefits on the basis of old age.

—A steady increase from 107,000 in December 1975 to 294,000 in September 1990 of the number of disabled and blind children under 18 receiving SSI benefits.

—A steady increase from 201,000 in December 1975 to 601,000 in September 1990 in the number of persons receiving benefits on the basis of disability or blindness who were age 65 and older.

—A recent sharp increase of 706,000 between 1983 and 1990 in the number of persons ages 22–64 receiving benefits on the basis of disability or blindness.

TABLE 15.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS AND NUMBER WITH CONCURRENT INCOME AND AVERAGE MONTHLY AMOUNT, BY REASON FOR ELIGIBILITY AND TYPE OF INCOME, SEPTEMBER 1990

Type of income	Total	Reason for eligibility		
		Aged	Blind	Disabled
Total number	4,764,351	1,451,601	83,673	3,229,077
	Number			
Social Security benefits	2,208,247	1,009,039	32,053	1,167,155
Other unearned income	617,256	266,607	9,180	341,469
Earned income	226,383	26,038	6,234	194,111
	Average monthly income			
Social Security benefits	$301.64	$306.99	$316.09	$296.63
Other unearned income	95.52	83.36	85.27	107.29
Earned income	195.46	198.45	497.20	185.37

Source: Office of Research and Statistics, Social Security Administration.

TABLE 16.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS AND UNEARNED INCOME (OTHER THAN SOCIAL SECURITY) AND AVERAGE MONTHLY UNEARNED INCOME, BY TYPE OF INCOME, SEPTEMBER 1990

Type of income	Number [1]	Average [2]
Total	617,256	$95.52
Veterans' benefits	132,550	146.27
Railroad retirement	6,094	286.92
Black lung benefits	1,970	267.29
Employment pensions	43,728	105.44
Worker's compensation	2,920	259.38
Support and maintenance in kind	171,693	90.45
Support from absent parents	22,701	134.38
Asset income	164,440	9.34
Assistance based on need	13,646	103.70
Other	57,514	205.10

[1] With unearned income other than social security benefits.

[2] Monthly amount of unearned income.

Source: Office of Research and Statistics, Social Security Administration.

SSI PARTICIPATION RATES

Table 17 shows SSI participation among the elderly using various measures. The numerator in all three columns is the sum of columns two and four in table 18. Column one simply divides the SSI aged participants, including the disabled population over age 65 by the total number of elderly. That rate declined from 11.1 percent in 1975 to 6.6 percent in 1988, primarily as a result of increasing incomes among the aged and decreasing participation among low-income elderly. Column two presents the number of elderly SSI recipients divided by the number of poor elderly. This rate has declined from 76 percent in 1975 to 54 percent in 1982. Between 1982 and 1984, this percentage increased, perhaps as a result of outreach efforts mandated by the 1983 Social Security Amendments (P.L. 98–21). After 1984, the rate declined to 56.5 percent in 1987 and has since risen again to 60.1 percent in 1989. This is a gross measure of participation, in that it does not control for other SSI eligibility factors, such as assets. The final column shows the number of SSI aged recipients as a percentage of the number of poor elderly before means-tested transfers.

TABLE 17.—SSI PARTICIPATION RATES

[In percent]

	Among all elderly	Among elderly poor	Among pretransfer elderly poor
1975	11.1	75.6	NA
1976	10.3	72.4	NA
1977	9.8	74.1	NA
1978	9.4	71.5	NA
1979	9.0	61.3	68.7
1980	8.7	57.5	64.7
1981	8.1	55.0	63.3
1982	7.5	53.6	62.3
1983	7.3	55.2	61.9
1984	7.3	61.2	66.3
1985	7.1	58.7	64.5
1986	6.9	57.9	63.4
1987	6.8	56.5	64.7
1988	6.6	57.6	64.3
1989	6.6	60.1	64.6

NA—Not available.

Note: The denominator for column 1 is in table 7, appendix M, the denominator for column 2 is shown in table 2 of appendix I and the denominator for column 3 is in table 21 of appendix I.

NUMBER OF RECIPIENTS: 1970–1990

Table 18 illustrates the changes in the number of individuals receiving assistance under the federally administered SSI program and prior programs. The total number of individuals receiving assistance was 3.1 million in 1970; this increased to 4.3 million in 1975 and declined to 3.9 million in 1982. Since then, the number of SSI recipients has grown each year. In 1990, there were over 4.8 million SSI recipients. The number of aged receiving SSI has declined sharply since 1975 from 2.3 million (or 2.5 million if disabled over age 65 are counted as aged) to 1.5 million individuals in 1990 (2.1 million if disabled over 65 are counted). The number of blind or disabled receiving assistance increased sharply from 1.0 million in 1970 to 3.4 million in 1990.

The number of individuals receiving only Federally administered State SSI benefits steadily declined from 1978 to 1983 as the number of mandatory State supplementation only cases declined, but starting with 1984, has steadily increased. In September 1990, Federally administered State supplementation only cases were up to 405,000.

TABLE 18.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS, 1974-1995; AND ADULT ASSISTANCE UNDER PRIOR PROGRAMS, 1970-1973

[In thousands]

Year [1]	Total [2]	Aged [3]	Blind or disabled		Federal SSI [6]	State supplemental only
			Total [4]	65 and older [5]		
1970	3,098	2,082	1,016			
1971	3,172	2,024	1,148			
1972	3,182	1,934	1,248			
1973	3,173	1,820	1,353			
1974	3,996	2,286	1,710	(7)	(8)	(8)
1975	4,314	2,307	2,007	201	3,893	421
1976	4,236	2,148	2,088	249	3,799	437
1977	4,238	2,051	2,187	302	3,778	460
1978	4,217	1,968	2,249	344	3,755	462
1979	4,150	1,872	2,278	386	3,687	462
1980	4,142	1,808	2,334	419	3,682	460
1981	4,019	1,678	2,341	443	3,590	429
1982	3,858	1,549	2,309	462	3,473	384
1983	3,901	1,515	2,386	485	3,590	311
1984	4,029	1,530	2,499	507	3,699	331
1985	4,138	1,504	2,634	525	3,799	339
1986	4,269	1,473	2,796	540	3,922	348
1987	4,385	1,455	2,930	560	4,019	366
1988	4,464	1,433	3,030	573	4,089	375
1989	4,593	1,439	3,154	587	4,206	387
1990	4,817	1,454	3,363	605	4,412	405
1991 [9]	4,865	1,460	3,405	615	4,460	405
1992 [9]	5,065	1,480	3,585	625	4,645	420
1993 [9]	5,265	1,505	3,760	635	4,830	435
1994 [9]	5,480	1,540	3,940	645	5,030	450
1995 [9]	5,695	1,575	4,120	655	5,225	470

[1] Data are for December of each year.

[2] All persons with Federal SSI payments and/or Federally administered State supplementation; 1974-1994. For 1970-1973, the total is the number of recipients under the Old-Age Assistance and Aid to the Blind and Aid to the Permanently and Totally Disabled Programs.

[3] For 1970-1973, this column is the number of recipients under the Old-Age Assistance program.

[4] For 1970-1973, this column is the number of recipients under the Aid to the Blind and Aid to the Permanently and Totally Disabled Programs.

[5] For 1974-1994, this is the number of age 65 or older individuals who first received SSI benefits because of being blind or disabled.

[6] All persons with Federal SSI payments include those receiving Federal payments only or both Federal SSI and Federally administered State supplementation.

[7] Data not available for December 1974. In January 1974, there were 87,000 blind and disabled recipients aged 65 or older.

[8] Data not available.

[9] For 1990-1994, these data are projections under current law.

Source: Office of Research and Statistics, and Office of Budget, Social Security Administration.

TABLE 19.—NUMBER OF PERSONS RECEIVING SSI PAYMENTS, BY STATE, DECEMBER 1990

State	Federally administered				State administered total [2]
	Total [1]	Aged	Blind	Disabled	
Total	4,817,127	1,454,041	83,686	3,279,400	282,120
Alabama	132,786	48,440	1,647	82,699	10,742
Alaska	4,640	1,138	97	3,405	[3] 4,726
Arizona	44,822	11,300	707	32,815	3,630
Arkansas	75,878	27,110	1,247	47,521	....
California	872,786	325,251	21,786	525,749	....
Colorado	37,569	8,720	462	28,387	29,535
Connecticut	32,061	6,820	475	24,766	24,383
Delaware	8,080	1,736	131	6,213	....
District of Columbia	16,223	3,467	221	12,535	....
Florida	221,796	82,117	3,213	136,466	12,258
Georgia	159,498	50,183	2,646	106,669	....
Hawaii	13,795	5,618	187	7,990	....
Idaho	10,351	1,918	146	8,287	[3] 2,985
Illinois	176,686	31,408	2,426	142,852	50,699
Indiana	60,153	10,498	1,181	48,474	829
Iowa	32,724	7,484	1,055	24,185	....
Kansas	24,534	4,991	373	19,170	....
Kentucky	114,686	29,063	1,946	83,677	6,563
Louisiana	132,978	40,278	2,264	90,436	....
Maine	23,694	6,862	264	16,568	....
Maryland	59,778	14,627	786	44,365	1,014
Massachusetts	119,354	46,683	4,436	68,325	....
Michigan	143,177	26,864	2,195	114,118	....
Minnesota	40,408	9,951	673	29,784	16,413
Mississippi	113,836	40,932	1,649	71,255	....
Missouri	84,983	21,425	1,135	62,423	5,363
Montana	9,977	1,790	124	8,063	....
Nebraska	15,562	3,356	233	11,973	7,130
Nevada	11,395	4,403	511	6,481	....
New Hampshire	6,875	1,403	90	5,382	4,579
New Jersey	105,378	30,796	1,164	73,418	....
New Mexico	31,556	9,429	604	21,523	258
New York	415,331	122,546	4,024	288,761	....
North Carolina	148,644	47,853	2,629	98,162	15,786
North Dakota	7,498	2,165	84	5,249	2
Ohio	155,758	23,361	2,519	129,878	....
Oklahoma	60,442	19,623	975	39,844	57,667
Oregon	31,575	6,305	559	24,711	16,855
Pennsylvania	190,506	41,586	2,878	146,042	....
Rhode Island	17,437	4,982	213	12,242	....

TABLE 19.—NUMBER OF PERSONS RECEIVING SSI PAYMENTS, BY STATE, DECEMBER 1990—Continued

State	Federally administered				State administered total [2]
	Total [1]	Aged	Blind	Disabled	
South Carolina	90,314	28,613	1,789	59,912	3,631
South Dakota	10,092	2,755	149	7,188	274
Tennessee	139,790	41,440	1,960	96,390	
Texas	294,716	119,889	5,215	169,612	
Utah	12,639	1,901	282	10,456	
Vermont	10,067	2,582	122	7,363	
Virginia	95,467	29,058	1,531	64,878	[3] 5,777
Washington	61,618	11,418	790	49,410	
West Virginia	47,202	8,947	672	37,583	
Wisconsin	85,783	21,912	1,150	62,721	
Wyoming	3,461	697	53	2,711	[3] 1,291
Unknown	230	99		131	
Other areas:					
Northern Mariana Islands [3]	538	248	18	272	

[1] Includes persons with Federal SSI payments and/or federally administered State supplementation, unless otherwise indicated.

[2] Represents August 1990 data.

[3] Estimated data.

Source: Office of Research and Statistics and Office of Supplemental Security Income, Social Security Administration.

Impact of the Sullivan v. Zebley *decision*

SSA has based its estimate of administrative costs to implement the *Zebley* case on the assumption that nationwide class relief will go back to January 1980. SSA has medically denied 452,000 child claims for SSI benefits since January 1980. The Agency has agreed to make significant efforts to find these individuals (or their representatives). Based on past experience, SSA can expect about 50 percent of the class to ask to have their claims reworked. This will create a disability claims workload of about 237,200 cases. In March 1991, the district court approved a settlement agreement that established an eligible class under *Zebley* back to January 1980.

As a result of the *Zebley* ruling, SSA expects to process 237,200 retroactive "*Zebley* claims," 74,700 reconsiderations, 33,100 hearings, and 6,800 Appeals Council reviews, as well as reevaluate an additional 60,000 claims for childhood disability benefits that were denied since the court decision.

SSA estimates that about 40–45 percent of the 297,200 claims will be approved. According to SSA, when the additional recipients anticipated as a result of the *Zebley* case and related childhood disability regulations are added to the rolls, the number of blind/disabled recipients is expected to increase by 15,000 in fiscal year 1991 and 110,000 in fiscal year 1992 (based on a January 1980 "class" date).

Eligibility of SSI Recipients for Medicaid

States have three options as to how they treat SSI recipients in relation to Medicaid eligibility. Section 1634 of SSI law allows the Social Security Administration to enter into agreements with States to automatically cover all SSI recipients with Medicaid eligibility. SSI recipients are not required to make a separate application for Medicaid under this arrangement. Thirty-one States and the District of Columbia chose this option, and SSI recipients in these States account for approximately 75 percent of all SSI recipients nationwide.

Under the second option, States elect to automatically provide Medicaid eligibility for all SSI recipients, but only if the recipient completes a separate application with the State agency which administers the Medicaid program. The six States of Alaska, Idaho, Kansas, Nevada, Oregon, and Utah and the Northern Mariana Islands affecting about 2.0 percent of SSI recipients nationwide, have elected this option.

The third and most restrictive option is known as the "209(b)" option, under which States may impose Medicaid eligibility criteria which are more restrictive than SSI criteria, so long as the criteria chosen were part of the State's approved Medicaid State plan in January 1972. The 209(b) States may be more restrictive in defining blindness or disability, or more restrictive in their financial requirements for eligibility. However, aged, blind, and disabled Medicaid applicants must be allowed to spend-down in 209(b) States, regardless of whether or not the State has a medically needy program. Thirteen States use the 209(b) option for Medicaid coverage of aged, blind, and disabled SSI recipients. About 22 percent of the SSI recipient population nationwide lives in these 209(b) States. The 13 States that use this option are:

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
Nebraska
New Hampshire
North Carolina
North Dakota
Ohio
Oklahoma
Virginia

An amendment included in the 1986 SSI disability amendments (P.L. 99-643) required effective July 1, 1987, that 209(b) States continue Medicaid coverage for those SSI recipients who were eligible for Medicaid under a State's more restrictive criteria the month before the individual becomes eligible under section 1619.

The same legislation required States, effective July 1, 1987, to provide for continued Medicaid coverage for those individuals who lose their eligibility for SSI when their income increases because they become newly eligible for Social Security benefits as an adult disabled child or because of an increase in their benefits as an adult disabled child. Disabled adult children who otherwise would be eligible for SSI continue to be considered SSI recipients for Medicaid purposes. Protection against loss of Medicaid will also be provided for certain blind or disabled individuals who lose their SSI benefits when they qualify for Social Security early aged widow's or widower's benefits beginning at age 60. The 1987 Budget Reconciliation Act provides that such individuals, who otherwise qualify for SSI on the basis of blindness or disability, will be deemed to be an SSI recipient for purposes of Medicaid eligibility until they become eligible for Medicare. This provision has been effective since July 1, 1988.

ELIGIBILITY OF SSI RECIPIENTS FOR FOOD STAMPS

Except in California and Wisconsin, which have converted food stamp benefits to cash that is included in the State supplementary payments, SSI recipients may be eligible to receive food stamps. SSI beneficiaries living alone or in a household where all other members of the household receive SSI benefits are categorically eligible for food stamps. These individuals can file for food stamps at an SSA office and do not need to meet the food stamp program income eligibility standards to participate in the program. However, SSI beneficiaries living in households where other household members do not receive SSI benefits are referred to the local food stamp office to file for food stamps. These households must meet the income eligibility standards to be eligible for food stamp benefits.

The interaction with the food stamp program has important financial implications for a State which desires to increase the income of its SSI recipients by $1.00. Because food stamps are reduced by $0.30 for each additional $1.00 of SSI income including State supplements, the State must expend $1.43 to obtain an effective $1.00 increase in SSI recipients' total income.

SPECIAL SSI BENEFITS, MEDICAID SERVICES, AND RELATED PROVISIONS FOR THE WORKING DISABLED

Historical development of provisions to remove work disincentives for the SSI disabled

Earned income disregards.—Since the inception of the SSI program in January 1974, a portion of the earned income of SSI recipients has been disregarded in determining the eligibility for and the amount of SSI benefits payable. Earned income disregards were included in the pre-SSI federally assisted State programs for the aged, blind, and disabled.

Social Security Disability Amendments of 1980 (P.L. 96-263)—Section 1619 temporary demonstration program.—Prior to the enactment of the section 1619 program in 1980, a disabled SSI recipient who worked faced a substantial risk of losing SSI benefits and frequently, Medicaid. Work was treated the same way it is now treated under the Social Security disability insurance (SSDI) program: after a trial work period, work at the substantial gainful activity (SGA) level ($500 or more of earnings per month) led to the loss of disability status and eventually benefits—even if the individual's total income and resources were well within the SSI need criteria. Thus, disabled individuals who could work or, at least, could have tried to work had a disincentive to work because of their fear of losing their SSI benefits or often more importantly their eligibility for health services under Medicaid.

The 1980 amendments established for a 3-year period, beginning January 1, 1981, special provisions under a new section 1619(a) of SSI law, for the provision of special SSI cash benefits to disabled individuals who lost their eligibility for SSI payments because they worked and were declared not disabled. Section 1619(b) provided for special SSI recipient status for Medicaid eligibility purposes for working disabled or blind individuals when they have earnings and their income makes them ineligible for cash payments.

Section 1619 program extended in 1984 and evaluation study conducted.—The Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460) extended the temporary authority of section 1619 through June 30, 1987. At the request of the Committee on Ways and Means, the Department of Health and Human Services conducted a study to evaluate the effectiveness of section 1619 in reducing work disincentives and to determine the characteristics of individuals benefiting from its protection. According to the report, over 55,000 individuals had benefited from the section 1619 program since its inception. The report also indicated that there was a net savings from the provisions of the section 1619 program. The section 1619 report was released July 30, 1986.

Section 1619 made permanent and SSI work incentives simplified.—In 1986, the Employment Opportunities for Disabled Americans Act (P.L. 99-643) made section 1619 permanent and made other modifications in section 1619 and other work-related provisions of SSI law including repeal of the trial work period and extended period of eligibility provisions of SSI disability law.

Establishing SSI disability status and retaining SSI disability status

Under the SSI and Social Security disability insurance (SSDI) law, the Secretary of HHS is required to prescribe the criteria for determining when employment or earnings from employment demonstrate an individual's ability to engage in substantial gainful activity (SGA). Current regulations provide that average countable earnings of over $500 a month over an extended period, generally not less than 6 months, indicate that an individual is able to engage in SGA. If an applicant for SSI or SSDI disability benefits has demonstrated the ability to engage in SGA they will not be able to establish an SSI disability status. Current law does provide for a deduction from earnings of extraordinary impairment related work expenses for purposes of determining whether an individual is able to engage in SGA.

However, under the provisions of the 1986 SSI Disability Amendments, Public Law 99-643, disabled individuals on the SSI rolls will retain disability status until they medically recover or their eligibility is terminated for a nondisability reason. A determination that an individual is engaging in substantial gainful activity will not be a factor in retaining SSI disability status. Instead, medical reviews of the individual's disabilities will be conducted to ensure that disability status is not continued for people who have medically recovered. Medical reviews are scheduled based on medical diaries and on work activity. The continuing disability determinations are based on medical improvement criteria.

Summary of section 1619 provisions intended to remove work disincentives for the disabled

Section 1619(a) of SSI law provides for the continuation of cash benefits for those SSI recipients who are receiving benefits on the basis of disability even if they are working at the SGA level and as long as there is not a medical improvement in the disabling condition. The amount of their cash benefits is gradually reduced as their earnings increase under the income disregard formula until their countable earnings reach the SSI benefit standard or what is known as the "breakeven point." In a State with no supplementation, as shown in table 1, this earned income eligibility limit is $899 per month in 1991. People who receive the special SSI benefits continue to be eligible for Medicaid on the same basis as regular SSI recipients. States have the option of supplementing the Federal benefits standard for those entitled to benefits under this provision. The "breakeven point" increases $2 for every $1 of State supplementation above the Federal SSI benefit standard.

Under section 1619(b), individuals can continue to be eligible for Medicaid even if their earnings take them past the SSI income disregard "breakeven point." This special eligibility status, under which the individual is considered a blind or disabled individual receiving SSI benefits for purposes of Medicaid eligibility, applies as long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continued to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the termination of eligibility for Medicaid services; and (4) had earnings that are not sufficient to provide a reasonable equivalent of the benefits (SSI, State supplementary payments, and Medicaid) that would have been available if he or she did not have those earnings.

In making an initial determination under the fourth criterion, the Social Security Administration decided to compare the individual's gross earnings to a "threshold" amount; i.e., the average expenditures for Medicaid benefits for disabled SSI cash recipients in the individual's State of residence. In other words, Medicaid eligibility continues until the individual's earnings reach a higher plateau which takes into account the person's ability to afford medical care as well as his or her normal living expenses, or they medically recover.

Under the provisions of Public Law 99-643, which was effective July 1, 1987, a disabled individual also has the ongoing protection of being able to be reinstated to eligibility to cash assistance benefits under regular SSI or 1619(a), or Medicaid only eligibility under 1619(b) if their work attempt fails or their physical or mental disability makes their ability to work very erratic. This protection is not indefinite, but the Social Security Administration, under the provisions of Public Law 99-643, will not terminate the disability status of an individual for 12 months after they were last eligible for regular SSI or eligible under section 1619(a) or 1619(b). However, if the individual recovers medically a new application and new disability determination would be required to establish a new period of eligibility.

SSI OUTREACH AND SPECIAL REHABILITATION SERVICES

The 1983 Social Security Amendments (P.L. 98-21) mandated the Social Security Administration (SSA) to conduct two separate outreach activities aimed at the aged population. The first was a one-time mailing of alerts to those aged individuals and couples whose Social Security benefits were less than the supplemental security income (SSI) eligibility levels. Between February and July 1984 over 7.6 million notices were mailed as part of this one-time alert. SSA used a mail survey questionnaire to evaluate the effects of this alert process. As a result of the one-time outreach effort, there were approximately 160,000 field office contacts. These contacts resulted in 79,000 applications for SSI payments and 58,000 awards, with an average monthly SSI payment of $60 to supplement these recipients' social security benefits. Most of the people who did not contact SSA after receiving the alert reported that they felt that they were ineligible because of too many resources or too much income.

The second outreach activity is an ongoing effort to notify two groups of Social Security beneficiaries: those about to reach age 65; and disabled individuals who have been receiving Social Security benefits for 21 consecutive months and will soon be eligible for Medicare. Beginning in July 1983, and continuing each month, approximately 110,000 aged and disabled social security beneficiaries receive an SSI alert which accompanies the Medicare enrollment notice. Eighty percent of the alerts go to retired beneficiaries, with the remainder sent to disability beneficiaries. The trend in SSI monthly aged awards showed a marked change when this mailing began. SSA estimates that about 2,000 additional aged awards per month have resulted from the ongoing alerts since July 1983.

As a result of these two outreach efforts, the decline in the aged SSI population was temporarily reversed, resulting in a high of 2,083,633 aged recipients in September 1984. Since that date, the aged SSI population has begun to decrease somewhat, although at a slower rate than that experienced before the outreach.

Under the SSI law, certain disabled and blind individuals are referred to the State vocational rehabilitation agency and SSI program funds are available to reimburse States for the cost of such services if the individual, as a result of such services, was able to earn at least $500 a month for at least 9 months.

Finally, the Omnibus Budget Reconciliation Act of 1989 established a permanent outreach program for disabled and blind children.

SSI AND THE HOMELESS

Evidence that approximately 30-40 percent of residents of emergency shelters for the homeless are the chronically mentally ill, including significant numbers of former residents of mental institutions, has led to the enactment of specific legislation and the development of outreach programs and administrative initiatives to better meet the needs of the homeless who may be eligible for SSI.

These initiatives are designed to address special problems related to the characteristics of the homeless: they are often difficult to locate and contact; they have limited ability to find information needed to make application; and they are often incapable or reluctant to follow through with the claim process. While many of the chronically mentally ill live with family or have other ongoing contact with those who can assist them with daily living activities, those mentally ill who are homeless are more likely to have very limited contact with family or others who could assist them in obtaining housing or applying for benefits.

As stated earlier, specific legislative changes were made in 1983 to respond to the needs of the homeless. In-kind support or maintenance provided by a private nonprofit organization is not counted as income under the SSI program if the State determines that the assistance is provided on the basis of need. While residents of most public institutions except small group homes are not eligible for SSI, temporary residents of public emergency shelters can receive SSI benefits for up to 6 months in any 9-month period.

The Social Security Administration also has statutory authority to provide emergency advance payments to individuals applying for SSI who are presumptively eligible for SSI in amounts up to the full SSI monthly benefit standard.

Administrative initiatives by the Social Security Administration to provide assistance to the homeless include:

Field offices in three counties in Maryland, northern Virginia and the District of Columbia and several homeless shelters, nutritional organizations, and advocates for the homeless have each established an SSI outreach Homeless Advisory Board. The board is comprised of district managers, case managers, homeless service providers, shelter managers and homeless advocates. Claims representatives on a rotational basis go once a month for half a day to selected shelters to take claims. The board determines what shelters will be used, the board looks at several factors; i.e., the size of the shelter, whether the shelters are male or female, shelters for families, long and short term facilities, nutritional sites, and shelters that service large numbers of people.

Many field offices have arrangements with soup kitchens to screen for potential SSI eligibles. Some even have arranged to distribute an SSI factsheet in every bag that goes out. Arrangements have been made with churches and synagogues to put SSI outreach fliers in their bulletins, and clergy will assist individuals in obtaining medical evidence.

Several of the regions have cooperative arrangements with the Disability Determination Service (DDS) to help to expedite claims. One such project is happening in New York City. In mid-January 1989, SSA, DDS, the New York City Human Resources Administration (HRA), and the Manhattan Bowery Corporation (MBC) designed a project to identify homeless women with serious mental impairments in New York City shelters. These women are assigned to a case manager for assistance in seeking housing, health care and financial benefits. New York City HRA, SSA, and DDS's part is making sure that the applications are completed correctly, medical evidence is provided timely and cases are flagged. Ten New York City shelters, and seven field offices are involved, New York City HRA and MBC received a grant under the McKinney Act to establish this homeless project.

SSA awarded 25 cooperative agreements in fiscal year 1990 to identify potentially eligible individuals and assist them with the application process. Of the 25, one cooperative agreement deals specifically with the homeless. The grantee will target the "unrelenting/cyclical" homeless population in Metropolitan Chicago, a majority of whose members are males and members of minority or ethnic groups (primarily African-Americans and Hispanics). They will test the effectiveness of providing all necessary application processing services during a single interview including on-the-spot consultative examinations for the homeless through the DDS and field office collaboration. The grantee will also provide intensive case management throughout the application process and will seek appropriate representative payee services.

Of the remaining 24 cooperative agreements, many of them are concentrating on the homeless in addition to other target populations. The grantees are dealing with the situation of rural homelessness and the nearly homeless who frequent soup kitchens and health clinics.

"Immediate payments."—Beginning in October 1985, local social security offices were given the authority to make "immediate payments" for certain Social Security and SSI cases when it is found that benefits are due but unpaid and even an expedited Treasury payment would result in deprivation of food and/or shelter or endangerment of health. "Immediate" usually means while the beneficiary waits or the next day at the latest. The payments are made using preprinted checks limited to a maximum per beneficiary of $200 or the amount due, whichever is less, in a 30-day period. The person's entitlement to benefits must be verified by the local office. During fiscal year 1987, 6,430 immediate payments were issued under this procedure. The total amount of these payments equaled $1,126,564 for an average of $175 per payment.

"Prerelease agreements."—Prerelease agreements between public mental institutions and local offices of the Social Security Administration have been a procedure available since the beginning of the SSI program. One of the purposes of these, usually informal, agreements is to identify those disabled individuals who upon release from an institution will be in need of immediate assistance if homelessness is to be prevented. Residents of large public institutions including State mental hospitals generally are not eligible for SSI. Therefore as part of the planning for the release of the patient, there is a determination of their meeting the disability criteria for SSI prior to leaving the institution. In addition, there is a determination that the individual will meet the other SSI eligibility criteria based on a projection of the individual's situation upon leaving the institution. When the decision is favorable, upon release from the institution an SSI payment can be made immediately.

From an evaluation by the Social Security Administration, it was found that 75 percent of the public mental hospitals and 63 percent of public institutions for the physically handicapped have entered into prerelease agreements with field offices of the Social Security Administration. The percentage for facilities for the mentally retarded or for the treatment of substance abuse was significantly lower. Also, SSA found that in general, prerelease agreements were underutilized. SSA has indicated that they are revising and streamlining the instructions on the use of prerelease agreements.

The 1987 Budget Reconciliation Act authorizes demonstration projects for States to establish projects to demonstrate special procedures and services to ensure that homeless individuals are provided SSI and other benefits to which they are entitled and to receive assistance in using such benefits to obtain permanent housing, food and health care. These projects would include the funding of multiagency SSI outreach teams of the type in operation in New York City.

SSI PROGRAM COSTS

Table 20 shows the program costs for the SSI program in fiscal years 1988, 1989, 1990 and estimated costs for fiscal years 1991 and 1992. In fiscal year 1990, approximately $11.5 billion of federally financed payments were made to the aged, blind, and disabled. The Federal Government's cost of administering the program was approximately $1 billion. Federal SSI benefits and the cost of administering the program are financed from general funds from the Treasury. The Social Security Administration also administers the payment of approximately $3.2 billion of State financed State supplementary payments. An additional $431 million was paid out in State administered State supplementation payments.

In fiscal year 1990, of the $12.5 billion of Federal SSI benefits, approximately $9.75 billion, or 78 percent, went to those who were eligible on the basis of disability; $2.5 billion, or 20 percent, to the aged; and $250 million, or 2 percent, to the blind.

In addition to the fact that a higher percent of the total SSI population were eligible on the basis of disability rather than age, the higher percent of Federal SSI payments for the disabled is also due to the fact that only 36 percent of the disabled have other income in the form of Social Security benefits compared to 70 percent of the aged.

Table 21 shows the total expenditures for the SSI program in each State, including not only the federally administered Federal and State supplementation payments but also the State administered State supplementation payments.

TABLE 20.—SSI FEDERAL PROGRAM COST BY ACTIVITIES, FISCAL YEARS 1988–92

[In millions of dollars]

Program by activities	1988	1989	1990	1991 (estimate)	1992 (estimate)
Direct program:					
Federal benefit payments [1]	11,368	11,483	11,462	15,551	[5] 16,105
Comparable 12 months of payments	(10,424)	(11,418)	(12,439)	(15,551)	(16,105)
Beneficiary services [2]	13	19	28	44	39
Payments to the trust funds for administrative costs [3]	975	1,051	1,075	[6] 1,278	1,444
Demonstration	([4])	1	3	8	11
Federal fiscal liability	−11	0	0	0	0
Total Federal direct program	12,345	12,554	12,568	16,881	17,599

[1] 1991 and 1992 reflect 12 months of payments in those fiscal years. 1988 reflects 13 months of payments including the check for October 1, 1988; 1989 reflects 12 months of payments including the check for October 1, 1989; and 1990 reflects 11 months of payments.

[2] Includes rehabilitation services provided to blind and disabled individuals, and monitoring of treatment of drug addicts and alcoholics.

[3] Includes cost of administering Federal SSI payments and federally administered State supplementation. These are not available separately.

[4] Less than $500,000.

[5] Includes one-time retroactive benefit payments to beneficiaries of the Sullivan v. Zebley decision. These benefit payments are estimated at $1.095 billion.

[6] Includes a supplemental appropriation request of $232 million to fund administrative costs resulting from the Zebley decision.

Source: Office of Research and Statistics, and Office of Budget, Social Security Administration.

TABLE 21.—SUPPLEMENTAL SECURITY INCOME: TOTAL PAYMENTS, FEDERAL SSI PAYMENTS, AND FEDERALLY ADMINISTERED AND STATE ADMINISTERED STATE SUPPLEMENTARY PAYMENTS, FISCAL YEAR 1990

[In thousands of dollars]

State	Total	Federal SSI	State supplementation	
			Federally administered	State administered
Total	16,095,428	12,506,080	[1] 3,158,595	430,753
Alabama	349,667	343,073		6,594
Alaska	26,336	13,364		[2] 12,972
Arizona	135,731	133,171		2,560
Arkansas	182,894	182,879	15	
California	4,139,017	1,864,721	2,274,296	
Colorado	149,063	106,414		42,649
Connecticut	161,322	93,652		67,670
Delaware	21,883	21,175	708	
District of Columbia	53,502	49,137	4,365	
Florida	648,769	634,113	0	14,656
Georgia	406,506	406,490	16	
Hawaii	50,891	40,006	10,885	
Idaho	31,993	27,781		[2] 4,212
Illinois	629,386	572,249		57,137
Indiana	171,363	168,078		3,285
Iowa	83,448	81,040	2,408	
Kansas	63,298	63,277	21	
Kentucky	339,599	327,988		11,611
Louisiana	370,110	370,085	25	
Maine	55,345	47,851	7,494	
Maryland	185,917	179,762	39	6,116
Massachusetts	386,634	269,521	117,113	
Michigan	468,827	394,145	74,682	
Minnesota	150,543	106,619		[2] 43,924
Mississippi	293,585	293,563	22	
Missouri	233,469	230,661		2,808
Montana	27,505	26,641	864	
Nebraska	46,403	40,610		5,793
Nevada	31,339	28,411	2,928	
New Hampshire	25,095	18,252		6,843
New Jersey	330,877	277,180	53,697	
New Mexico	86,196	85,933		263
New York	1,512,044	1,123,894	388,150	
North Carolina	456,438	393,303		63,135
North Dakota	19,551	18,161		[2] 1,390

TABLE 21.—SUPPLEMENTAL SECURITY INCOME: TOTAL PAYMENTS, FEDERAL SSI PAYMENTS, AND FEDERALLY ADMINISTERED AND STATE ADMINISTERED STATE SUPPLEMENTARY PAYMENTS, FISCAL YEAR 1990—Continued

[In thousands of dollars]

State	Total	Federal SSI	State supplementation	
			Federally administered	State administered
Ohio	467,206	467,172	34	
Oklahoma	188,582	154,414		34,168
Oregon	110,627	92,681		17,946
Pennsylvania	616,215	536,644	79,571	
Rhode Island	51,537	39,808	11,729	
South Carolina	237,369	228,472		8,897
South Dakota	25,597	25,030	18	549
Tennessee	374,034	374,030	4	
Texas	732,661	732,661		
Utah	36,091	35,283	808	
Vermont	30,136	21,451	8,685	
Virginia	266,278	250,982		[2] 15,296
Washington	199,874	179,959	19,915	
West Virginia	142,364	142,364		
Wisconsin	281,335	181,059	100,276	
Wyoming	9,221	8,942		[2] 279
Northern Mariana Islands	1,926	1,926		

---

[1] Payments reduced by $173,000 to reflect returned checks and overpayment refunds not distributed by State.

[2] Data estimated.

Source: Office of Research and Statistics, Social Security Administration.

Table 22 illustrates the total amount of Federal and State benefit payments from calendar years 1970 to 1987 and fiscal years 1988 to 1990. From 1970 to 1973, these were the benefits under the old-age assistance, aid to the blind, and aid to the permanently and totally disabled programs. In fiscal year 1990, Federal benefit payments totaled $12.507 billion and State payments totaled $3.589 billion.

TABLE 22.—FEDERAL AND STATE BENEFIT PAYMENTS UNDER SSI AND PRIOR ADULT ASSISTANCE PROGRAMS, CALENDAR YEARS 1970–87 AND FISCAL YEARS 1988–90

[Outlays in millions of dollars]

Year [1]	Total	Total constant 1990 dollars	Federal payments	Total State payments	State payments	
					Federally administered	State administered
1970	2,939	9,990	1,801	1,138		
1971	3,206	10,346	([2])	([2])		
1972	3,392	10,606	1,993	1,398		
1973	3,418	10,062	1,987	1,432		
1974	5,246	13,908	3,833	1,413	1,264	149
1975	5,878	14,280	4,314	1,565	1,403	162
1976	6,066	13,934	4,512	1,554	1,388	166
1977	6,306	13,601	4,703	1,603	1,431	172
1978	6,552	13,134	4,881	1,671	1,491	180
1979	7,075	12,737	5,279	1,796	1,590	207
1980	7,941	12,596	5,866	2,074	1,848	226
1981	8,593	12,355	6,518	2,076	1,839	237
1982	8,981	12,164	6,907	2,074	1,798	276
1983	9,404	12,340	7,423	1,981	1,711	270
1984	10,372	13,047	8,281	2,091	1,792	299
1985	11,060	13,434	8,777	2,283	1,973	311
1986	12,081	14,407	9,498	2,583	2,243	340
1987	12,951	14,900	10,029	2,922	2,563	359
1988	14,375	15,882	11,368	3,007	2,645	362
1989	14,707	15,502	11,399	3,308	2,881	427
1990	16,095	16,095	12,507	3,589	3,159	431

[1] 1970–1973 refers to Old-Age Assistance, Aid to the Blind and Aid to the Permanently and Totally Disabled; 1974–1990 refers to Supplemental Security Income.

[2] Data not available.

Source: Office of Research and Statistics, and Office of Budget, Social Security Administration.

Section 10. Title XX Social Services Block Grant Program

THE EVOLUTION OF THE SOCIAL SERVICES BLOCK GRANT PROGRAM

In 1974, Congress enacted Public Law 92-672, which created a new title XX of the Social Security Act authorizing an entitlement for States for social services funds with certain goals for the program, public participation planning requirements, limitations on activities which could be funded, and eligibility requirements. Prior to that time the States were entitled to receive Federal matching funds for social services under the various public assistance titles of the Social Security Act. In 1972, Congress established a $2.5 billion annual ceiling on the entitlement with each State's share determined on the basis of its population relative to the total population of all the States. When title XX was enacted, the $2.5 billion ceiling was retained along with the allocation formula. Table 1 shows the title XX funding levels from 1977 through present law.

By fiscal year 1981 the entitlement ceiling for allocation to States for social services was $2.9 billion. In addition, $16.1 million of title XX funds was available for the territories for social services and $75 million was available to the States for staff training costs related to title XX activities. Thus, a total of $2,991,100,000 was available to States and territories for social services and training in fiscal year 1981 under title XX. As part of Public Law 96-272, enacted in 1980, the ceiling was increased from $2.9 billion to $3 billion for fiscal year 1982 and was increased by $100 million a year until it reached $3.3 billion for fiscal year 1985.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) amended title XX of the Social Security Act to establish a "Block Grant to States for Social Services" which combined the funding for social services for the States and territories and social services staff training. Public Law 97-35 reduced the title XX entitlement ceiling to $2.4 billion for fiscal year 1982 and provided for increases to $2.45 billion for fiscal year 1983, $2.5 billion for fiscal 1984, $2.6 billion for fiscal 1985 and $2.7 billion for fiscal 1986 and years thereafter. This law also eliminated Federal mandates regarding priority recipients, and eliminated provisions relating to the targeting of services to low-income individuals and families.

The emergency jobs bill (Public Law 98-8), enacted in March 1983, appropriated an additional $225 million for fiscal year 1983 but which also was available for carryover to fiscal year 1984. These additional funds were allocated to the States on the basis of a formula intended to respond to the needs of the unemployed served by the jobs bill. One-half of the funds was allocated on the basis of population; one-third based on the number of unemployed individuals in the State; and one-sixth among those States whose average unadjusted unemployment rate from June 1982 through November 1982 was 9.4 percent or higher. In October 1983, as part of legislation to extend the Federal supplemental compensation program (Public Law 98-135) the title XX ceiling was increased by $200 million for fiscal 1984 to $2.7 billion and by $100 million for fiscal year 1985 to $2.7 billion.

Because of the concern by Congress of reports of child sexual abuse in day care centers, a $25 million increase in title XX funding for fiscal year 1985 was appropriated for use by the States in providing training of child day care staff, State licensing and enforcement officials, and the parents of children in child day care. The earmarked funds were included in the continuing resolution for fiscal year 1985 (Public Law 98-473). States were required to have in effect by September 30, 1985, procedures for screening and conducting background and criminal history checks of child care staff, or one-half of the day care training allotment was to be deducted from the regular State title XX allocation in fiscal year 1986 or 1987. According to HHS, only six States enacted such procedures by the required date. As required by Public Law 98-473, in January 1985, the Secretary of HHS distributed to States a Model Child Care Standards Act with particular attention to staff training and supervision, employment history checks, and parent visitation.

The 1987 Budget Reconciliation Act (Public Law 100-203) included a $50 million increase in the title XX entitlement ceiling for fiscal year 1988. These funds were not appropriated.

The Medicare and Medicaid Patient Program Act of 1987 (Public Law 100-93) amended title XX by adding a new section 2005(a)(9). This new section excludes individuals and entities who have committed acts of fraud or abuse under the Medicaid, Medicare, Maternal and Child Health, or the title XX programs from receiving title XX funds.

The Omnibus Reconciliation Act of 1989 (Public Law 101-239) included a permanent $100 million increase in the title XX entitlement ceiling to $2.8 billion, beginning for fiscal year 1990.

TITLE XX ALLOCATION FORMULA AND HISTORICAL FUNDING LEVELS

Title XX social services block grant funds are allocated to the States on the basis of population. The allotments for Puerto Rico, Guam, the Virgin Islands and the Northern Marianas from the national total are based on their allocation for fiscal year 1981 adjusted to reflect the new total funding level. The 1987 Budget Reconciliation Act (Public Law 100-203) extended eligibility for title XX funds to American Samoa. The Federal funds are available to States without a State matching requirement, compared to the 25-percent State matching required for most of the title XX funds available to States under the old title XX law.

Table 1 shows the title XX funding levels, in both nominal dollars and real 1990 dollars, from fiscal year 1977 and through the current law's entitlement ceiling for fiscal year 1992 and future years. Over the 10-year period (1980 to 1990), title XX funding has declined in real terms by $1,726 million, a reduction of 38 percent. Table 2 shows the total funds available to each State and territory under title XX in fiscal years 1989 through 1992.

TABLE 1.—TITLE XX SOCIAL SERVICES BLOCK GRANT FUNDING LEVELS

[In millions of dollars]

Fiscal year	Entitlement ceiling	
	Nominal dollars	1990 dollars
1977	[1] 2,796	5,790
1978	[1] 2,791	5,430
1979	[1] 2,991	5,343
1980	[2] 2,791	4,488
1981	[2] 2,991	4,368
1982	[3] 2,400	3,275
1983	[4] 2,675	3,491
1984	2,700	3,380
1985	[5] 2,725	3,292
1986	[6] 2,584	3,045
1987	2,700	3,094
1988	2,700	2,970
1989	2,700	2,834
1990	[7] 2,762	2,762
1991	2,800	2,658
1992 and future years	2,800	....

---

[1] Included $16 million for Puerto Rico, Guam and the Virgin Islands and $59 million in fiscal year 76, $80 million in fiscal year 77 and $75 million in fiscal years 78 and 79 for title XX staff training.

[2] Included $16.1 million for Puerto Rico, Guam, the Virgin Islands and the Northern Marianas and $75 million for title XX staff training.

[3] Public Law 97–35 eliminated separate funding for title XX staff training.

[4] Includes $225 million appropriated in the emergency jobs bill (Public Law 98–8).

[5] Includes $25 million earmarked for training of day care providers, licensing officials and parents including training in the prevention of child abuse in child care settings.

[6] The entitlement ceiling for fiscal year 1986 was $2.7 billion. However, the Gramm-Rudman-Hollings legislation sequestration of funds for fiscal year 1986 reduced the funding by $116 million to $2.584 billion.

[7] The entitlement ceiling for fiscal year 1990 was $2.8 billion. However, the Gramm-Rudman-Hollings legislation sequestration of funds for fiscal year 1990 reduced the funding by $37.8 million to $2.762 billion.

Note.—Nominal dollars converted to constant 1990 dollars using the CPI–X1 price index.

TABLE 2.—TITLE XX SOCIAL SERVICES BLOCK GRANT ALLOCATIONS BY STATE AND TERRITORY

[In millions]

	Fiscal year—			
	1989	1990	1991 estimate	1992 estimate
Total	$2,700.0	$2,762.0	$2,800.0	$2,800.0
Alabama	45.1	46.1	46.5	46.2
Alaska	5.9	6.2	5.9	5.9
American Samoa	.2	.2	.2	.2
Arizona	36.5	39.6	39.5	39.9
Arkansas	26.4	26.8	27.1	27.0
California	300.5	314.1	320.7	326.0
Colorado	36.4	37.5	37.4	37.2
Connecticut	35.5	36.2	36.6	36.3
Delaware	7.1	7.3	7.5	7.5
District of Columbia	7.0	6.9	7.0	6.8
Florida	130.0	137.0	139.7	142.1
Georgia	68.0	71.4	71.8	72.2
Guam	.5	.5	.5	.5
Hawaii	11.8	12.3	12.4	12.5
Idaho	11.2	11.3	11.4	11.4
Illinois	128.7	129.6	131.6	130.8
Indiana	61.3	61.9	62.9	62.7
Iowa	31.8	31.4	32.1	31.9
Kansas	27.4	27.7	28.3	28.2
Kentucky	41.5	41.8	42.2	41.8
Louisiana	50.1	50.4	49.9	49.1
Maine	13.1	13.3	13.7	13.7
Maryland	49.7	51.4	52.4	52.6
Massachusetts	65.0	65.4	66.7	66.3
Michigan	101.9	103.3	104.7	104.0
Minnesota	46.9	47.8	48.8	48.8
Mississippi	29.2	29.8	29.7	29.4
Missouri	56.4	57.4	58.2	57.9
Montana	9.1	9.1	9.1	9.0
Nebraska	17.8	17.8	18.1	18.1
Nevada	10.7	11.4	11.9	12.5
New Hampshire	11.4	12.2	12.3	12.4
New Jersey	84.9	86.8	87.5	86.8
New Mexico	16.5	17.4	17.1	17.1
New York	198.0	198.6	202.9	201.3
North Carolina	70.5	72.8	73.5	73.7

TABLE 2.—TITLE XX SOCIAL SERVICES BLOCK GRANT ALLOCATIONS BY STATE AND TERRITORY—Continued

[In millions]

	Fiscal year—			
	1989	1990	1991 estimate	1992 estimate
North Dakota	7.6	7.5	7.6	7.4
Northern Mariana Islands	.1	.1	.1	.1
Ohio	119.8	120.6	123.0	122.3
Oklahoma	36.8	36.8	36.7	36.2
Oregon	30.1	30.6	31.3	31.6
Pennsylvania	132.4	132.7	135.9	135.0
Puerto Rico	14.0	14.3	14.5	14.5
Rhode Island	10.9	11.1	11.2	11.2
South Carolina	37.6	38.8	39.3	39.4
South Dakota	7.9	7.9	8.1	8.0
Tennessee	53.5	54.7	55.4	55.4
Texas	185.8	192.3	190.7	190.6
Utah	18.5	19.3	19.1	19.1
Vermont	6.0	6.2	6.3	6.4
Virgin Islands	.5	.5	.5	.5
Virginia	64.5	66.9	68.1	68.4
Washington	49.7	51.1	52.6	53.4
West Virginia	21.4	21.1	21.3	20.8
Wisconsin	53.3	53.7	55.0	54.6
Wyoming	5.6	5.6	5.4	5.3

Source: Department of Health and Human Services.

TITLE XX PROGRAM GOALS

The purpose of the title XX social services block grant program is to provide assistance to States to enable them to furnish services directed at the five goals of the statute:

—Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

—Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

—Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;

—Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and

—Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

States are given wide discretion as to the services to be provided and the groups who may be eligible for services, usually low income families and individuals. In addition to supporting social services, the law allows States to use their allotment for staff training, administration, planning, evaluation, and purchasing technical assistance in developing, implementing, or administering the State social service program. States decide what amount of the Federal allotment to spend on services, training, and administration.

Some restrictions are placed on the use of title XX funds. Funds cannot be used for the following: most medical care except family planning; rehabilitation and certain detoxification services; purchase of land, construction, or major capital improvements; most room and board except emergency short-term services; educational services generally provided by public schools; most social services provided in and by employees of hospitals, nursing homes, and prisons; cash payments for subsistence; child day care services that do not meet State and local standards; and wages to individuals as a social service except wages of welfare recipients employed in child day care.

DATA ON SERVICES, RECIPIENTS AND EXPENDITURES UNDER TITLE XX

To date, there has been very limited information available on the use of title XX funds by the States. Under the title XX social services block grant program each State must submit a report to the Secretary of Health and Human Services on the intended use of its funds. These preexpenditure reports are only required to include information about the types of activities to be funded and the characteristics of the individuals to be served.

The Family Support Act of 1988, Public Law 100-485, will strengthen reporting requirements. The new legislation requires States to submit annual reports containing detailed information on the services actually funded and the individuals served through title XX funds. The Office of Human Development Services, HHS, published a notice of proposed rulemaking on April 5, 1990, to implement the reporting requirements and propose uniform definitions of services.

Table 3 is a comparison of the primary services offered by the States taken from a summary of the preexpenditure reports for fiscal years 1983 through 1990 prepared by the Department. Based on these reports, it appears that the most frequently provided services are: day care for children; home-based services; protective services for children; adoption services; social support services; and special services for the disabled. Fiscal year 1979 is the most recent year for which data are available on the percentage of total title XX dollars spent for various types of social services.

In addition to the preexpenditure reports, another source of data on title XX is from the Voluntary Cooperative Information System (VCIS) of the American Public Welfare Association funded by HHS.[1] The VCIS is a national data base comprised of aggregate

---

[1] This discussion of the VCIS summary is drawn directly from: "A Statistical Summary of the VCIS Social Services Block Grant (SSBG) Data for FY 86," American Public Welfare Association, February 1990.

State program statistics. A total of 37 State agencies participated in the data gathering activity for fiscal year 1986. The VCIS data base is incomplete even for these States since a number of States were able to provide only partial data or their data could not be used due to lack of conformity with the reporting guidelines. Furthermore, the VCIS data base is comprised of both estimated and actual service and expenditure data. In the absence of more complete data, however, the data can be used to describe the characteristics of recipients, services and expenditures in the fifth year of implementation of the social services block grant for the States supplying information. However, without the application of an appropriate sampling technology, it is not possible to determine the extent to which the data can be generalized to the nation as a whole.

VCIS data from 21 States show that six services account for about one-half of all services provided to recipients, measured in terms of recipient counts. These services are as follows: information and referral services (10 percent); protective services for children (14 percent); preventive services for children and their families (8 percent); child day care services (8 percent); counseling services (3 percent); and substitute care and placement services for children (7 percent). Examples of other services provided include case management; assessment; community utilization and access; Medicaid transportation; refugee services; and prosthetic and orthopedic services to adults.

Data from 16 States show that 28 percent of recipients were served without regard to income; 14 percent were SSI recipients; 31 percent were income-eligible by State standards; 20 percent were AFDC recipients; 5 percent were income-eligible Medicaid recipients; and for 2 percent, the eligibility category was unknown.

VCIS data from 35 States show that the Federal title XX social services block grant dollars combined with other Federal dollars (e.g., title IV-B, WIN, etc.) accounted for 60 percent of the total social service expenditures in the States during fiscal year 1986, while State dollars accounted for 37 percent of the total. Local dollars and private contributions accounted for 3 percent of the total.

Data from 31 States show that four services accounted for well over one-half of the expenditures through the social services block grant in fiscal year 1986. These services include child day-care services (14 percent); substitute care and placement services for children (14 percent); protective services for children (10 percent); and home-based services (21 percent). Data from 28 States show that 58 percent of the total expenditures were for services provided directly by public agencies, while 42 percent were for services provided by private/voluntary providers under purchase-of-service agreements.

TABLE 3.—COMPARISON OF THE NUMBER OF STATES [1] OFFERING SELECTED SERVICES FOR FISCAL YEARS 1983–90

Services	1983	1984	1985	1986	1987	1988	1989	1990
Adoption	36	38	37	39	34	29	30	35
Case management [2]					34	26	23	26
Counseling	30	28	32	38	33	22	21	21
Day care—adults	37	29	26	31	24	23	26	26
Day care—children	50	50	52	52	48	51	47	45
Education/training	28	31	31	43	40	19	16	17
Emergency [3]						15	14	16
Employment [3]						21	24	23
Family planning	35	31	33	30	31	26	27	26
Foster care—adults	25	20	16	19	15	12	10	10
Foster care—children	34	34	33	31	30	29	30	30
Health-related	26	23	27	36	26	22	21	23
Home based [4]	51	51	55	55	49	45	42	46
Home delivered/congregate meals	23	24	24	28	20	20	20	20
Housing improvement	14	12	13	18	9	10	11	16
Information and referral	36	34	37	34	25	23	20	25
Legal	17	16	18	17	14	17	13	13
Placement	18	13	19	20	20	17	14	16
Prevention/intervention [5]	11	28	26	35	30	33	25	27
Protective—adults	44	45	42	46	40	34	30	30
Protective—children	52	47	46	54	47	38	38	42
Residential care/treatment	19	26	24	29	25	21	27	25
Social support [6]	2	30	30	25	27	27	37	45
Special services—children	19	24	22	28	10	27	17	19
Special services for the disabled	36	6	39	41	31	39	38	34
Special services for juvenile delinquents [2]					19	16	12	14
Substance abuse services	7	14	14	13	12	10	12	11
Services for unmarried parents	10	10	12	10	10	13	13	13
Transportation	25	25	29	33	27	30	27	25
Other [7]	5	27	35	36	7	20	17	19

[1] Includes 50 States, the District of Columbia, and the 5 eligible Insular areas.

[2] Identified as separate service for the first time in 1987. This is not meant to imply that the service was first available in 1987.

[3] Identified as a separate service for the first time in 1988. This is not meant to imply that the service was first available in 1988.

[4] Home based services include: homemaker, chore, home health, companionship, and home maintenance.

[5] Prevention/Intervention Services include: Investigation/assessment, family centered early intervention, home evaluation and supervision, preventive and restorative.

[6] Social Support Services include: socialization, recreation, camping, physical activity, living skills (money management), day treatment, family development, social adjustment, community living services, family management, life skills education, personal and financial management.

[7] Other Services include: social services in correctional facilities, services to Hispanics, homeless services, and Indian reservation services.

Source: U.S. Department of Health and Human Services—Fiscal Year Preexpenditure Reports.

TRANSFER OF FUNDS AMONG BLOCK GRANTS

Public Law 97-35, which created the title XX block grant, gave States the authority to transfer up to 10 percent of their annual allotment to one or any combination of the three health care block grants and/or the low-income home energy assistance block grant. (The three health care block grants are: the preventive health and health services block grant; the maternal and child health services block grant; and the alcohol, drug abuse, and mental health services block grant.) In turn, most other block grant statutes allow States to transfer funds to the title XX program.

According to the fiscal year 1990 preexpenditure reports submitted to HHS by States, two States planned to transfer title XX funds to other programs. Florida planned to transfer funds to the alcohol, drug abuse, and mental health services block grant program, and North Carolina planned to transfer funds to the maternal and child health services block grant and the preventive health and health services block grant programs. Fourteen States planned to transfer funds from the low-income home energy assistance block grant to supplement title XX funds.

TITLE XX SOCIAL SERVICES PLANNING AND PROGRAM INFORMATION

Comprehensive Annual Services Plans (CASP)

Prior to 1981, the title XX law and regulations required States to publish and make available for public comment a Comprehensive Annual Services Plan (CASP). States were required to make known through public notices the availability of the CASP and provide opportunity for comment prior to finalizing the plans for the use of the title XX funds.

The law required that the title XX CASP plan include the (1) objectives to be achieved, (2) services to be provided, (3) categories of individuals to be served, (4) geographic areas in which services are to be provided, (5) estimated expenditures, (6) location of resources, (7) coordination with related programs, (8) organizational structure of the administering agency, and (9) planning, evaluation, and reporting activities.

The Comprehensive Annual Services Plan was also sent to the Department of Health and Human Services. Such State plans were the basis of a summary and an analysis of States' planned use of title XX funds which was published by the Department each year until 1980.

While the Comprehensive Annual Services Plan did not allow for an aggregation of the various types and State-defined categories of social services, it did provide in one document a compilation of the States' title XX plans. It allowed for an analysis of States' uses of Federal title XX funds for such target groups as the aged, the disabled, and children, and for an analysis of the various types of services which the States had provided for in their title XX funded programs.

In addition to forwarding to HHS their title XX Comprehensive Annual Services Plan, States were also required to provide information to HHS under a system which aggregated State data into commonly defined categories of social services activities. This system was the Social Services Reporting Requirements (SSRR) and produced reports which aggregated the data from the States and included over 1,000 different State-defined social service categories into 41 Federal categories.

Title XX Preexpenditure Reports

Since 1981, States have only been required to submit to the Department of Health and Human Services an annual "preexpenditure report." While some States provide as part of this annual report data similar to those included in the pre-1981 Comprehensive Annual Services Plan, for most States the preexpenditure report provides very minimal information on the uses which States intend to make of their title XX allocations.

In an attempt to determine trends and current expenditures by the States for certain social services categories, HHS was asked to utilize the preexpenditure reports and summarize expenditures for day care services for children; protective services for children; and home care services. For those three categories, and for only those States that included such services in their reports for fiscal years 1980, 1983, 1986, 1987, 1988, 1989, and 1990, the estimates for their title XX program expenditures for each of those service categories have been listed in table 4.

As can be seen from the data in table 4, there are major changes in a State's reported expenditures for a certain service which, without further clarification, limits the value of the use of only preexpenditure reports for understanding trends or current expenditures for certain social service categories.

TABLE 4.—DATA FROM PREEXPENDITURE REPORTS ON TITLE XX EXPENDITURES FOR SELECTED STATES FOR THREE SELECTED SERVICES: FISCAL YEARS 1980, 1983, 1986, 1987, 1988, 1989, AND 1990

[In thousands of dollars]

	1980	1983	1986	1987	1988	1989	1990
				Home Based Services			
Alabama	5,198	5,478	4,480	2,750	2,631	2,533	2,533
Arkansas	2,018	2,184	1,479	2,071	412	364	579
Delaware	509	570	461	420	519	491	474
Georgia	5,227	4,329	3,018	1,858	1,741	1,724	1,640
Illinois	28,690	60,090	26,010	5,622	6,343	4,426	1,955
Indiana	6,630	6,213	7,308	4,130	4,473	8,724	84
Iowa	13,004	853	352	465	NA	NA	NA
Kentucky	3,707	2,049	2,219	5,872	2,055	3,110	4,438
Mississippi	2,127	2,492	3,182	2,315	1,000	500	1,982
New Mexico	3,558	2,811	1,888	1,901	1,693	1,453	1,493
South Carolina	4,990	3,625	5,373	3,663	2,294	2,016	2,314
West Virginia	9,224	4,294	5,268	5,736	2,742	3,335	2,695
Wyoming	1,118	911	1,292	1,451	NA	NA	NA
				Protective Services for Children			
Alabama	9,843	12,627	13,702	19,114	26,857	21,004	20,425
Arkansas	1,561	1,859	2,283	2,256	2,256	NA	3,154
Georgia	8,351	4,445	3,253	6,457	6,344	6,902	14,670
Indiana	6,657	9,662	10,545	8,967	NA	NA	NA
Iowa	6,138	7,042	3,806	3,743	3,858	NA	9,910
Kentucky	4,445	4,697	9,063	11,764	12,894	10,910	9,768
Mississippi	1,290	1,784	2,653	3,677	935	935	8,180
New Mexico	1,700	1,951	1,938	3,173	4,105	2,427	1,556
Pennsylvania	15,297	2,256	2,526	6,178	NA	NA	8,745
South Carolina	5,329	5,806	7,086	5,315	5,742	5,598	5,840
Virginia	6,654	10,962	12,312	14,220	14,661	15,288	NA
West Virginia	3,253	2,703	3,627	3,556	3,469	3,689	4,388
Wyoming	68	59	134	1,570	NA	NA	NA
				Day Care for Children			
Alabama	18,062	10,301	7,699	9,661	10,823	2,155	2,155
Arkansas	1,851	1,392	3,238	3,174	73,174	3,690	3,690
Delaware	4,240	1,862	2,004	2,483	2,683	2,354	1,841
Georgia	21,339	14,752	14,117	14,117	12,61	12,617	2,397
Illinois	40,911	46,928	40,870	29,426	56,364	28,502	23,370
Indiana	9,500	8,435	7,407	7,088	8,012	8,014	7,925
Iowa	4,537	2,149	2,969	3,273	3,016	752	4,574
Kentucky	4,295	3,530	4,171	5,393	4,878	5,306	5,650
New Mexico	3,388	2,220	2,241	2,313	5,185	2,488	3,888
Pennsylvania	74,811	41,806	42,419	40,289	39,904	39,904	38,775
South Carolina	12,520	10,923	12,072	9,047	9,179	177	8,676
Virginia	11,527	6,933	2,937	3,258	2,961	2,857	2,082
West Virginia	6,856	4,042	3,700	3,628	3,559	3,759	3,753
Wyoming	1,337	1,024	2,328	3,214	NA	NA	NA

NA—Not available.

Source: Department of Health and Human Services.

Reporting Requirements of the Family Support Act of 1988

The Family Support Act of 1988, Public Law 100-485, enacted at the end of the 100th Congress, amended the title XX legislation to strengthen its reporting provisions. The new legislation requires States to submit annual reports containing the following information:

—The number of individuals served with title XX funds, with separate breakdowns for numbers of children and adults, also broken down by type of service received;

—Amounts spent for each type of service, broken down by child and adult recipients;

—Eligibility criteria used for receiving services; and

—Service delivery methods, broken down by public versus private agencies, and by type of service provided.

The welfare legislation also requires the Secretary of HHS to establish uniform definitions of services. The Office of Human Development Services, HHS, issued a notice of proposed rulemaking on April 5, 1990 to implement the new reporting requirements, and propose uniform definitions of services and an annual reporting form. At the time of publication, final regulations were not yet promulgated.

Section 11. Child Welfare, Foster Care, Adoption Assistance

BACKGROUND

Child welfare services focus on improving the conditions of children and their families and on improving or providing substitutes for functions the parents have difficulty in performing. Many private, nonprofit and government entities work to provide a range of child welfare services to families in need. The primary responsibility for child welfare services in the government, however, rests with the States. Each State has its own legal and administrative structures and programs that address the needs of children and there are many differences among the States. The Federal Government has also been involved in efforts to improve the welfare of children in specific areas of national concern since the early 1900's and numerous Federal programs provide support for such services today, including several programs under titles IV–B and IV–E of the Social Security Act. In addition, services relating to child welfare may be provided at State discretion under the social services block grant program (title XX of the Social Security Act).[1]

Child welfare services encompass a broad range of activities, including child protection, care of the homeless and neglected, child social and nutritional development, and children in out-of-home care. The services provided may be supportive (e.g., help the family cope with problems or provide protection for children while the family learns to perform appropriate parenting roles); supplementary (e.g., provide financial assistance); or substitutive (e.g., foster care).[2]

It is generally agreed that it is in the best interests of children to live with their families. To this end, experts emphasize the value of preventive and rehabilitative services intended to help families stay together whenever possible, and emphasize the need to limit the duration of foster care placements by returning children to their homes whenever appropriate and finding permanent living arrangements for children who cannot be returned home.

This philosophy is reflected in the Federal programs authorized under titles IV–B and IV–E which support services to promote the welfare of children. Title IV–B authorizes funds to States for child welfare services and title IV–E authorizes the foster care, independent living, and adoption assistance programs. The child welfare and foster care programs are intended to operate in consort to help prevent the need for out-of-home placement of children and, in cases where such placement is necessary, to provide protections and permanent placement for the children involved. In addition, funding is provided under the foster care program to assist States with the maintenance costs of low-income (AFDC-eligible) children in foster care. The independent living program is intended to help States facilitate the transition of children from foster care to independent living; and the adoption assistance program is primarily to help States support the adoption of AFDC- or SSI-eligible children with "special needs" such as ethnic background, age, membership in a sibling group, or a mental or physical handicap.

---

[1] At the Federal level, programs that fund child welfare services (in addition to those under titles IV–B, IV–E and XX) include Head Start, and several programs that provide funding directed at specific problems, such as child abuse, homelessness, runaways, and teenage pregnancy.

[2] This typology is adapted from Kadushin, Alfred, and Judith A. Martin. Child Welfare Services. Macmillan Publishing Co., New York, 1988. pp. 26–28.

AFDC FOSTER CARE UNDER TITLE IV-A: 1961-1980

Federal assistance to enable States to make maintenance payments for children who were not living with a parent and had been placed elsewhere by a child welfare agency—that is, who were living in foster care—first became available under what was then called the Aid to Dependent Children (ADC) program (title IV-A of the Social Security Act) in 1961.

The legislation that authorized this assistance (P.L. 87-31) was developed to resolve a controversy surrounding the practice by some States of denying ADC benefits to otherwise eligible children if the homes in which they continued to live were found to be "unsuitable." In 1961, the Department of Health, Education, and Welfare (HEW) issued a ruling (later called the Flemming Rule) prohibiting States from this practice. The rule stipulated that States were either to continue assistance payments while making efforts to improve home conditions or provide other living arrangements for such children. Congress acted to assist States in complying with the Flemming Rule by authorizing a temporary program of Federal matching funds for ADC payments for children placed in foster care as a result of a judicial determination that continued residence in the home was detrimental (P.L. 87-31). As enacted, the program authorized Federal aid for payments on behalf of children in foster care who had been receiving ADC in the month when court proceedings were initiated.

Congress made the program permanent the following year. Subsequent amendments: made the program mandatory for the States; extended payments to children in private, nonprofit institutions; and broadened eligibility to include children who would have been eligible for ADC benefits if application for the program was made during the month court proceedings to remove children were initiated, or who were not living with a relative when court proceedings were initiated but would otherwise have been eligible if they had been living with the relative 6 months prior to this time.

Data on the foster care program under title IV-A are incomplete. Even after 1969, when all State AFDC programs were required to provide foster care payments, separate reporting of this component of the program often was not made for several subsequent years. However, it is clear that both the number of children served and program expenditures grew rapidly after 1969. During that year, 30 States reported benefits for approximately 16,800 children. By the mid-1970s, all States were reporting, and the number of children receiving benefits had topped 100,000. The title IV-A foster care population grew from approximately one-half of 1 percent of the total AFDC recipient child population in 1969 to nearly 1½ percent of that population in 1980. (In 1990, this portion of the foster care population was an estimated 2.2 percent of the AFDC recipient child population.)

During the 1970s, a number of concerns were raised about the prevalence of foster care utilization in this country. Table 21 shows that from 1962 to 1988, for every 1,000 children, on average approximately four to five were in foster care. Although the use of foster care was recognized as an important and necessary tool for child serving agencies to effectively protect and provide for the welfare of children, it was considered generally undesirable to keep children in foster care—particularly for long periods of time—rather then in other, more permanent arrangements. It was suggested that the level of foster care utilization could be reduced by placing a greater emphasis on services aimed at working with the family to prevent the need for placement, by instituting improved tracking systems for those placed in substitute care coupled with periodic reviews to evaluate the appropriateness of continuing such care, and by putting greater emphasis on returning foster children to their original families or placing them in adoptive homes.

The avoidance of long-term foster care was urged whenever possible because it was believed the absence of a permanent home put the social, emotional, and psychological development of a child at significant risk. Proponents of a change in policy also argued that the additional costs of services aimed at achieving permanency placement might be more than offset by a subsequent reduction in the costs associated with providing full maintenance for a child for many years in the AFDC foster care system. Therefore, it was suggested that Federal policy provide fiscal incentives for foster care placements by coupling funding for maintenance costs with funding of services, such as preplacement prevention and reunification, that were aimed at reducing these maintenance expenditures.

Under the AFDC program, any State expenditures for foster care were matched by the Federal Government at the same rate applied to all AFDC benefits (generally 50 percent to 83 percent depending on State per capita income). Federal funding for foster care under AFDC grew to over $200 million by the late 1970s. However, the AFDC foster care program funded only the expenses associated with maintenance payments and related administrative costs. After 1972, Federal support for preventive and permanency services was available only through the child welfare services and title XX programs. Neither of these provided open-ended funding.

The child welfare services program under title IV–B was more clearly targeted at the types of services needed to reduce foster care dependency, but funding was limited. Although the authorization for the program had increased to $266 million under the 1972 amendments, the actual program funding remained well below this level (only $56.5 million in 1979). Moreover, since the AFDC program only covered about one-third of what appears to have been the overall foster care population, States used the title IV–B program as a funding source for foster care maintenance for those foster children that did not meet the eligibility requirements of the AFDC program. The entire Federal payment for child welfare services represented a relatively small proportion of the amount that State and local governments had to spend just on maintenance costs alone. For example, according to estimates by the Department of Health and Human Services (HHS), 73 percent of the total $786 million spent by States for child welfare services (including both Federal and State funds) went for foster care maintenance payments in 1979.

FACTORS LEADING TO 1980 LEGISLATIVE REFORM

By the late 1970s the arguments for a review of Federal policy relating to child welfare and foster care services coalesced around several key concerns:

(1) It was widely argued that the Federal Government should encourage States to prevent inappropriate foster care placements and insure that children remained in substitute care only as long as necessary. Several studies published during the 1970s noted that foster care placement was often the alternative used when other services (such as those designed to make it possible for children to remain in their own homes, or be reunited with their families) were not available. It was argued that an incentive existed for States to use foster care placements for children eligible under title IV–A (for which the Federal match was unlimited) rather than providing preventive or rehabilitative services (primarily funded at the State or local level) for at-risk families.

Much concern was also expressed about the length of time children were left in foster care. In 1977, a study sponsored by HEW found that 58 percent of all children in foster care had been there for more than 2 years and that 2½ years was the median length of stay in substitute care. Child welfare researchers noted that the likelihood of a child's exit from foster care decreased with the length of stay.

In addition, the concern was also expressed that States should pursue a policy of permanency planning, consisting of interviews at the time of initial placement, goal setting, and periodic reevaluations—mechanisms aimed at ensuring that children are placed appropriately and not simply forgotten once they entered the foster care system.

(2) Particular attention was given to the situation of those foster children who were hard to place in permanent homes. It was argued that older children, children with physical or other disabilities, children who were ethnic minorities, and children belonging to a sibling group were less adoptable, in part because many families were financially unable to afford the costs associated with adoption. Such an adoption was often particularly costly because of either the financial status of a compatible prospective family, or because of the medical and other expenses associated with the special needs of these children. Federal coverage of these childrens' expenses (including Medicaid, for which children receiving AFDC foster care were eligible) would cease once they were adopted unless the adoptive parents were themselves eligible for AFDC for reasons other than those posed by the adoption. During the course of the decade most of the States enacted laws that provided some type of subsidies for maintenance payments and/or medical serv-

ices to assist parents that adopted hard-to-place children. However, such programs were limited and no Federal funds were provided for this purpose. Arguments were made that Federal assistance in this area would serve the best interests of the child by increasing its chances for an adoptive placement. Moreover, assuming the assistance enabled parents to adopt children that they otherwise would not, such a program would be cost-effective because the average cost per child would be less than the cost of maintaining a child in AFDC foster care.

(3) Other concerns expressed about the foster care program under title IV-A related to the lack of data on the number of children receiving services, including the length of time these children remained in care, the specific services provided, the cost of these services, and the demographic characteristics of the recipient population. Questions were also raised about the necessity and desirability of continuing to limit Federal funding of AFDC foster care to cases in which the child had been removed from the home by the action of a court. Similar questions were raised about the nonavailability of Federal matching for institutional foster care in public facilities, particularly small facilities that might offer a more desirable alternative to the care provided by large nonprofit institutions.

Many of these concerns were discussed during hearings in the mid- to late-1970s. In 1980, the Adoption Assistance and Child Welfare Amendments of 1980 were enacted (P.L. 96-272), modifying both the child welfare services and foster care programs, transferring the foster care program from title IV-A to title IV-E, and establishing a new adoption assistance program under title IV-E. This legislation included incentives to States to help reduce long-term foster care.

THE ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980 (P.L. 96-272) AND SUBSEQUENT AMENDMENTS

AFDC foster care, which had been part of the general program of Aid to Families with Dependent Children (AFDC) under title IV-A of the Social Security Act, was amended by Public Law 96-272. This legislation continued AFDC foster care as a required Federal matching grant program, but transferred it to a newly created title IV-E. It also changed the funding mechanism for this program and the child welfare services program under title IV-B, providing linkages between the two to encourage less reliance on foster care placement and greater use of services aimed at preventing placement and encouraging family rehabilitation. The entitlement nature of AFDC foster care was retained, but under title IV-E its open-endedness is potentially limited by a provision that is contingent on the funding level of title IV-B. The legislation specified a number of protections to help prevent inappropriate placements or long-term stays in foster care, and a number of programs were established to provide services to specialized foster care populations. Under title IV-E a new Federal matching grant program for payments to parents who adopt a child with special needs was also established and permanently authorized. Funding for adoption assistance is on an open-ended entitlement basis.

The foster care and adoption assistance programs were amended in the 99th Congress, under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272). This legislation also established a new entitlement program under title IV-E to help States facilitate the transition of children age 16 and over from AFDC foster care to independent living. The program is called the independent living program.

During the 99th Congress, legislation was also enacted as part of the Tax Reform Act of 1986 (P.L. 99-514) that amended the adoption assistance program under title IV-E to provide for Federal matching funds for the one-time adoption expenses of children with special needs, whether or not the children are eligible for AFDC or SSI payments.

During the 100th Congress, legislation was enacted to expand the independent living program to include children ages 16 or over who are in any foster care situation and to provide services for specified children for 6 months after foster care payments or foster care ends (P.L. 100-647).

During the first session of the 101st Congress, legislation was enacted as part of the Omnibus Reconciliation Act of 1989 (P.L. 101-239) to increase the authorization level of the IV-B program from $266 million to $325 million; and to extend the independent living program through 1992, increase the entitlement ceiling from $45 million to $50 million for fiscal year 1990, $60 million for fiscal year 1991, and $70 million for fiscal year 1992 and establish a State match beginning for fiscal year 1991.

During the second session of the 101st Congress, the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) made several minor amendments to the child welfare, foster care and adoption assistance programs. Among other things, these amendments now require States to distinguish between traditional administrative costs and child placement costs which previously had been classified as administrative costs, and give States the option of providing independent living services to foster children up to age 21.

FEDERAL CHILD WELFARE PROGRAMS TODAY

The Social Security Act contains four primary sources of funds available to States for child welfare, foster care, and adoption activities. These funds include both nonentitlement authorizations (under which specific appropriations are made for a program, effective for 1 year, a fixed number of years, or permanently) and authorized entitlements (under which the Federal government has a binding obligation to make payments to any person or unit of government that meets the eligibility criteria established by law). The four programs include the title IV-B child welfare services program, the title IV-E foster care program, the title IV-E adoption assistance program, and the title XX social services block grant program. Table 1 lists the four programs, as well as the recently established independent living program, and their funding environments.

Table 2 provides data on the level of Federal funds which have been used by or allocated to States under titles IV-B, IV-E and XX for fiscal years 1981 through 1989, and projections for fiscal years

1990 through 1992. Under the title XX social services block grant program, States have discretion over what portion of their allocation they will spend on child welfare, foster care and adoption activities, as well as a range of other activities not directly focused on children. As this table shows, detailed data on child welfare services spending by States under the title XX program are not available.

In addition to the funds allocated to the States or available on an entitlement basis, approximately $11.4 million was appropriated for fiscal year 1991 for research and demonstration activities authorized under section 426 of title IV–B for direct Federal grants to public and private entities for child welfare staff training and child welfare research and demonstration projects.

Funds available to States from the title IV–B child welfare program and title XX social services program may be used for services to families and children without regard to their eligibility for AFDC. Federal matching funds for foster care maintenance payments under title IV–E are only provided in those cases where the child would have been eligible for AFDC if still in the home. All children determined to have "special needs" related to their being adopted, as defined under title IV–E, are eligible for reimbursement of certain nonrecurring costs of adoption under the title IV–E adoption assistance program. However, only AFDC- or SSI-eligible "special needs" children are eligible for federally matched adoption assistance payments available under title IV–E. Funds available to States for the title IV–E independent living program may be used for services which facilitate the transition of children from foster care to independent living, regardless of whether or not they receive AFDC foster care assistance. Table 3 provides data on participation under the title IV–B, IV–E and XX programs. As this table demonstrates, only limited data are available on participation in these programs.

TABLE 1.—FUNDING ENVIRONMENT OF THE FEDERAL PROGRAMS WHICH SUPPORT FOSTER CARE, CHILD WELFARE, AND ADOPTION SERVICES

Program	Budgetary classification	Federal support of total
Title IV–E Foster Care Program:		
Foster care assistance payments.	Authorized entitlement	Open-ended Federal match at Medicaid rate.
Placement services and administrative costs.	Authorized entitlement	Open-ended Federal match of 50 percent.
Training expenses	Authorized entitlement	Open-ended Federal match of 75 percent.
Title IV–E Adoption Assistance Program:		
Adoption assistance payments	Authorized entitlement	Open-ended Federal match at Medicaid rate.
Nonrecurring adoption expenses.	Authorized entitlement	Open-ended Federal match of 50 percent.[1]
Placement services and administrative costs.	Authorized entitlement	Open-ended Federal match of 50 percent.
Training expenses	Authorized entitlement	Open-ended Federal match of 75 percent.
Title IV–E Independent Living Program.	Authorized entitlement	100 percent Federal funding, with a funding ceiling.[2]
Title IV–B Child Welfare Services Program.	Nonentitlement authorization.	Federal match of 75 percent, total capped at State allotment.
Title XX Social Services Block Grant Program.	Authorized entitlement	100 percent Federal funding, with a funding ceiling.

[1] The Federal Government reimburses 50 percent of up to $2,000 of expenditures for any one placement.

[2] Beginning for fiscal year 1991, States will be required to provide 50 percent matching for any Federal funding claimed that exceeds $45 million.

TABLE 2.—FEDERAL FUNDING FOR CHILD WELFARE, FOSTER CARE, AND ADOPTION ACTIVITIES UNDER TITLES IV–B, IV–E, AND XX OF THE SOCIAL SECURITY ACT, 1981–92, UNDER CURRENT LAW

[In millions of dollars]

Fiscal year	Title IV–B child welfare services	Title IV–E foster care State claims			State use of FC funds for IV–B, CWS (transfers)	Title IV–E independent living program	Title IV–E adoption assistance State claims				Title XX SSBG program (CWS portion)
		Total [1]	Maintenance payments	Placement services, admin., training			Total	Assistance payments	Nonrecurring payments	Placement services, admin., training	
1981	163.6	308.8	278.4	30.4	74.1	....	0.5	0.4	....	0.1	NA
1982	156.3	373.8	301.3	72.5	20.6	....	4.7	4.5	....	.2	NA
1983	156.3	394.8	276.9	117.9	32.6	....	12.6	11.3	....	1.3	NA
1984	165.0	445.2	297.8	147.4	32.2	....	24.2	18.7	....	5.5	NA
1985	200.0	546.2	355.3	190.9	19.6	....	37.2	29.0	....	8.2	NA
1986	[2] 198.1	[2] 637.2	408.9	228.3	14.9	....	54.7	40.6	....	14.1	NA
1987	222.5	792.6	479.7	312.9	11.3	[3] 45	73.7	53.9	....	19.8	NA
1988	239.4	927.6	545.3	382.3	5.1	45	97.5	74.2	....	23.3	NA
1989	246.7	1,194.4	686.4	508.0	1.6	45	113.3	87.2	0.1	26.0	NA
1990 (estimate)	252.6	1,477.0	843.9	633.1	5.3	50	140.5	105.4	2.5	32.6	NA
1991 (estimate)	273.9	1,828.5	1,010.1	818.4	1.0	60	169.9	128.6	2.7	38.6	NA
1992 (estimate)	[4] 363.9	2,222.6	1,172.7	1,049.9	1.0	70	201.8	154.3	3.0	44.5	NA

[1] Total does not include transfers to the title IV–B child welfare services program.

[2] Funding level for fiscal year 1986 reflects a 4.3 percent reduction in the $207 million IV–B child welfare funds appropriated, due to the sequestration under the Gramm-Rudman-Hollings legislation. Funding level for title IV–E foster care includes a $6 million reduction from funds because of the denial of Federal matching required under the fiscal year 1986 sequestration order.

[3] States did not begin receiving funds until July 1987; States were allowed to spend the fiscal year 1987 carryover funds in fiscal year 1989.

[4] Based on proposed legislation.

NA—Not available.

Source: Department of Health and Human Services.

TABLE 3.—PARTICIPATION IN CHILD WELFARE, FOSTER CARE, AND ADOPTION ACTIVITIES UNDER TITLES IV–B, IV–E, AND XX OF THE SOCIAL SECURITY ACT, 1981–91, UNDER CURRENT LAW

Fiscal year	Title IV–B child welfare services	Title IV–E foster care assistance payments [1]	State use of FC funds for IV–B, CWS (transfers)	Title IV–E independent living program [2]	Title IV–E adoption assistance		Title XX SSBG program (CWS portion)
					Assistance payments [1]	Nonrecurring payments	
1981	NA	104,851	NA	....	165	....	NA
1982	NA	97,309	NA	....	2,402	....	NA
1983	NA	93,360	NA	....	5,309	....	NA
1984	NA	102,051	NA	....	11,581	....	NA
1985	NA	109,122	NA	....	16,009	....	NA
1986	NA	110,749	NA	....	21,989	....	NA
1987	NA	118,549	NA	20,182	27,390	....	NA
1988	NA	132,757	NA	18,931	34,698	164	NA
1989	NA	156,658	NA	44,191	40,666	260	NA
1990 (estimate)	NA	173,152	NA	NA	44,026	2,384	NA
1991 (estimate)	NA	197,393	NA	NA	49,970	NA	NA

[1] Participation defined as the average monthly number of recipients.

[2] Data on participation in the title IV–E independent living program are based on State plans, and show number participating in a program activity at some time during the fiscal year.

NA—Not available.

Source: Department of Health and Human Services.

THE TITLE IV-B CHILD WELFARE SERVICES PROGRAM

The child welfare services program under title IV-B permanently authorizes 75 percent Federal matching grants to States for services that protect the welfare of children. These services are to address problems that may result in neglect, abuse, exploitation or delinquency of children; prevent the unnecessary separation of children from their families and restore children to their families, when possible; place children in adoptive homes if restoration is not possible; and assure adequate foster care when children cannot return home or be placed for adoption. There are no Federal income eligibility requirements for the receipt of the child welfare services.

Requirements in Public Law 96-272 limited the use of title IV-B funds for child day care, foster care maintenance payments and adoption assistance payments to the 1979 title IV-B appropriation of $56.6 million. In addition, States are required to implement certain foster care protections for all children in foster care in order to be eligible for child welfare services funding over specified levels. States must also implement these foster care protections in order to transfer funds from their title IV-E foster care program to the child welfare services program. (The foster care protections and transfer mechanisms are described later in this section.)

The authorization level for the child welfare services program was $266 million annually since fiscal year 1977. The authorization level has been increased to $325 million under Public Law 101-239 beginning for fiscal year 1990. Appropriations for the program increased from $163.6 million in fiscal year 1981 to $273.9 million in fiscal year 1991 (see table 15).

Child welfare services funds are distributed to States on the basis of their under-21 population and per capita income. Because of minimal reporting requirements under the program, there are no reliable national or State-by-State data on the exact number of children served, their characteristics, or the services provided. Table 4 details the State-by-State distribution of child welfare services funds in fiscal years 1990 and 1991.

TABLE 4.—TITLE IV–B CHILD WELFARE SERVICES: STATE-BY-STATE ALLOCATIONS

[In thousands of dollars]

	Fiscal year—	
	1990 actual	1991 appropriation
Totals	252,648	273,911
Alabama	5,219	5,620
Alaska	323	560
Arizona	3,935	4,297
Arkansas	3,159	3,361
California	24,203	26,458
Colorado	3,284	3,474
Connecticut	2,004	2,118
Delaware	668	715
District of Columbia	443	468
Florida	10,749	11,744
Georgia	7,418	7,983
Hawaii	1,172	1,247
Idaho	1,454	1,572
Illinois	10,850	11,461
Indiana	6,260	6,662
Iowa	3,052	3,215
Kansas	2,588	2,773
Kentucky	4,618	4,934
Louisiana	6,095	6,353
Maine	1,385	1,473
Maryland	3,793	4,064
Massachusetts	4,225	4,487
Michigan	9,460	10,023
Minnesota	4,241	4,537
Mississippi	3,923	4,244
Missouri	5,323	5,641
Montana	1,069	1,122
Nebraska	1,955	2,082
Nevada	998	1,121
New Hampshire	681	1,083
New Jersey	5,099	5,399
New Mexico	2,126	2,276
New York	14,354	15,209
North Carolina	7,394	7,897
North Dakota	869	906
Ohio	11,449	12,167
Oklahoma	3,967	4,105
Oregon	2,930	3,162

TABLE 4.—TITLE IV–B CHILD WELFARE SERVICES: STATE-BY-STATE ALLOCATIONS—Continued

[In thousands of dollars]

	Fiscal year—	
	1990 actual	1991 appropriation
Pennsylvania	11,313	11,982
Rhode Island	971	1,030
South Carolina	4,468	4,865
South Dakota	963	1,013
Tennessee	5,653	6,137
Texas	20,212	21,425
Utah	2,980	3,184
Vermont	518	715
Virginia	5,498	5,892
Washington	4,568	4,956
West Virginia	2,343	2,513
Wisconsin	5,175	5,429
Wyoming	657	688
American Samoa	169	175
Guam	357	375
Northern Mariana	121	124
Puerto Rico	3,651	7,084
Virgin Islands	296	310

Source: Department of Health and Human Services, Office of HDS, ACYF.

THE TITLE IV–E AFDC FOSTER CARE PROGRAM

The AFDC foster care program under title IV–E is a permanently authorized entitlement program that provides open-ended matching funds to States for the maintenance payments made for AFDC-eligible children in foster care family homes or child care institutions housing up to 25 people. The program is required of States participating in the AFDC program (all States participate). The Federal matching rate of total expenditures for a given State is that State's Medicaid matching rate, which averages about 53 percent nationally. States may also claim open-ended Federal matching at a rate of 50 percent for their child placement services and administrative costs for this program and at a rate of 75 percent for State training expenditures (for training of personnel employed or preparing for employment by the State or local agency administering the program) and training of foster and adoptive parents.

States are *required* to provide foster care maintenance payments to AFDC-eligible children removed from the home of a relative if the child received or would have been eligible for AFDC prior to removal from the home and if the following apply: (1) the removal and foster care placement were based on a voluntary placement agreement [3] or a judicial determination that remaining in the home would be contrary to the child's welfare and reasonable efforts were made to eliminate the need for removal or to return the child to his home; and (2) care and placement of the child are the responsibility of specified public agencies. Children in the AFDC foster care program are eligible for Medicaid and the State in which the child resides is responsible for providing the Medicaid coverage.

The maintenance payments under the title IV–E foster care program are for the costs of food, shelter, clothing, daily supervision, school supplies, general incidentals, liability insurance for the child, and reasonable travel to the child's home for visits.

Foster care expenditures and participation rates

The average estimated monthly number of children in AFDC foster care has more than doubled between 1982 and 1991, from 97,000 in fiscal year 1982 to an estimated 197,000 in fiscal year 1991 (see table 3). Table 5 provides a State-by-State breakdown of estimated fiscal year 1990 foster care expenditures and participation. Note that California and New York account for over 45 percent of the estimated fiscal year 1990 participation (as measured in this table), and about 54 percent of 1990 expenditures.

TABLE 5.—TITLE IV–E FOSTER CARE EXPENDITURES, TITLE IV–B TRANSFERS, AND NUMBER OF CHILDREN—FISCAL YEAR 1990

State	Foster care expenditures (thousands)	IV–B transfers (thousands)	Fiscal year 1990 average monthly number of children
Alabama	$1,848	$1,498	990
Alaska	3,385		344
Arizona	7,890		821
Arkansas	3,526		421
California	293,560		41,417
Colorado	5,507		2,004
Connecticut	19,556		2,109
Delaware	1,511		242
District of Columbia	6,253		459
Florida	27,384		3,392
Georgia	12,804		2,590
Hawaii	157	292	40
Idaho	1,280		146
Illinois	65,835		9,280
Indiana	2,344	1,565	1,809

---

[3] "Voluntary placement" is defined as "out-of-home placement of minor, by or with participation of a State agency, after the parents or guardian of the minor have requested the assistance of the agency and signed a voluntary placement agreement." "Voluntary placement agreement" is defined as "a written agreement, binding on the parties of the agreement, between the State agency, any other agency acting on its behalf, and the parents or guardians of a minor child which specifies, at a minimum, the legal status of the child and rights and obligations of the parents or guardians, the child, and the agency while the child is in placement" (sec. 472(ff)).

TABLE 5.—TITLE IV–E FOSTER CARE EXPENDITURES, TITLE IV–B TRANSFERS, AND NUMBER OF CHILDREN—FISCAL YEAR 1990—Continued

State	Foster care expenditures (thousands)	IV–B transfers (thousands)	Fiscal year 1990 average monthly number of children
Iowa	5,702		1,212
Kansas	19,542		1,096
Kentucky	23,532		1,538
Louisiana	21,526		2,666
Maine	7,182		777
Maryland	14,936		740
Massachusetts	20,121		3,225
Michigan	84,423		8,139
Minnesota	22,532		2,136
Mississippi	1,035	1,183	686
Missouri	16,804		2,472
Montana	2,783		435
Nebraska	5,606		1,027
Nevada	2,357		465
New Hampshire	3,120		413
New Jersey	18,885		3,024
New Mexico	5,003		694
New York	508,059		37,954
North Carolina	4,995		2,472
North Dakota	2,620		319
Ohio	44,965		5,034
Oklahoma	5,397		845
Oregon	13,380	718	2,240
Pennsylvania	76,075		9,149
Rhode Island	6,045		572
South Carolina	6,356		1,245
South Dakota	1,905		225
Tennessee	11,385		1,780
Texas	1,080		3,619
Utah	2,876		406
Vermont	6,366		866
Virginia	9,247		2,048
Washington	12,931		2,768
West Virginia	11,622		1,128
Wisconsin	23,049		3,598
Wyoming	631		82
Total	1,476,913	5,256	173,152

Source: Department of Health and Human Services, Office of HDS, ACYF.

State claims for child placement services and administrative costs for the title IV–E foster care program increased considerably between 1982 and 1989. Current HHS regulations give the following examples of allowable child placement services and administrative costs for the foster care program: referral to services, preparation for and participation in judicial determinations, placement of the child, development of the case plan, case reviews, case management and supervision, recruitment and licensing of foster homes and institutions, rate setting, and a proportionate share of agency overhead. As discussed later, many of these activities are required of States (i.e., they are foster care "protections") to be eligible for additional child welfare services funds. Table 6 provides a State breakdown of foster care expenditures in fiscal year 1989 between maintenance payments and administration and training expenditures. A more detailed discussion of growth in child placement services and administrative costs is contained later in this section.

TABLE 6.—FEDERAL FOSTER CARE EXPENDITURES UNDER TITLE IV–E, FISCAL YEAR 1989

[Dollars in millions]

State	Maintenance payments	Child placement services and administration	Training	Total	Child placement services and administration as percent of total
Alabama	$1.75	$0.29	$0.00	$2.04	14.22
Alaska	1.38	1.30	.01	2.69	48.33
Arizona	2.55	4.52	.09	7.16	63.13
Arkansas	.56	1.39	.22	2.17	64.06
California	136.15	86.13	1.24	223.52	38.53
Colorado	3.12	2.33	.23	5.68	41.02
Connecticut	6.48	3.62	.19	10.29	35.18
Delaware	.62	1.15	.03	1.80	63.89
District of Columbia	7.60	2.20	.00	9.80	22.45
Florida	7.51	10.12	.70	18.33	55.21
Georgia	6.03	5.73	.63	12.39	46.25
Hawaii	.07	.01	.00	.08	12.50
Idaho	.31	.18	.00	.49	36.73
Illinois	24.63	19.84	2.86	47.33	41.92
Indiana	1.81	.29	.00	2.10	13.81
Iowa	2.50	2.10	.30	4.90	42.86
Kansas	4.23	1.82	.06	6.11	29.79
Kentucky	7.40	11.13	1.49	20.02	55.59
Louisiana	9.30	8.62	.09	18.01	47.86
Maine	3.36	2.98	.16	6.50	45.85
Maryland	6.05	9.62	.57	16.24	59.24
Massachusetts	6.97	9.50	.00	16.47	57.68

TABLE 6.—FEDERAL FOSTER CARE EXPENDITURES UNDER TITLE IV–E, FISCAL YEAR 1989—Continued

[Dollars in millions]

State	Maintenance payments	Child placement services and administration	Training	Total	Child placement services and administration as percent of total
Michigan	44.25	26.30	.11	70.66	37.22
Minnesota	9.20	11.06	.61	20.87	52.99
Mississippi	.94	.04	.00	.98	4.08
Missouri	8.27	8.41	.43	17.11	49.15
Montana	1.63	.35	.01	1.99	17.59
Nebraska	2.66	1.78	.20	4.64	38.36
Nevada	.78	.86	.08	1.72	50.00
New Hampshire	1.94	1.44	.00	3.38	42.60
New Jersey	7.09	10.15	.50	17.74	57.22
New Mexico	1.65	1.45	.03	3.13	46.33
New York	223.72	108.09	11.68	343.49	31.47
North Carolina	2.44	.21	.00	2.65	7.92
North Dakota	1.30	.37	.02	1.69	21.89
Ohio	16.14	22.99	2.24	41.37	55.57
Oklahoma	3.51	3.36	.01	6.88	48.84
Oregon	6.68	5.88	.00	12.56	46.82
Pennsylvania	53.92	8.99	.58	63.49	14.16
Rhode Island	2.39	3.38	.11	5.88	57.48
South Carolina	2.35	2.50	.18	5.03	49.70
South Dakota	.91	1.66	.38	2.95	56.27
Tennessee	3.86	6.15	.00	10.01	61.44
Texas	12.92	43.12	.80	56.84	75.86
Utah	1.59	.82	.08	2.49	32.93
Vermont	2.64	2.45	.04	5.13	47.76
Virginia	3.88	7.53	.04	11.45	65.76
Washington	10.17	7.64	.04	17.85	42.80
West Virginia	8.76	1.48	.35	10.59	13.98
Wisconsin	10.14	6.88	.00	17.02	40.42
Wyoming	.31	.37	.02	.70	52.86
Total	686.42	480.58	27.41	1,194.41	40.24

Source: Department of Health and Human Services, Office of HDS, ACYF.

Foster care payment rates

Table 7 shows each State's basic title IV–E foster care maintenance rates that are paid out on a monthly basis. The rates vary widely. For instance, in 1989 the basic monthly rate for a 16-year-old foster child in the State of Mississippi was $175 compared with $477 in the State of Maryland and $504 in the State of Hawaii. New York City had a monthly payment rate of $505. The nationwide average for this age group was $338 per month compared with $268 for 2-year-olds and $292 for foster children that were 9 years of age. Thirty-five of these States included a clothing allowance in this basic rate.

In July of 1989 the American Public Welfare Association conducted a State-by-State assessment of reimbursement rate policies for certain special populations. The results are shown in table 8. According to the survey, 18 States have special policies for foster children that are HIV positive or infected with the AIDS virus, eight States have similar policies for drug-addicted infants, 46 for relatives caring for foster children, 14 for day care, and 29 for liability damages.

TABLE 7.—FOSTER CARE BASIC MONTHLY MAINTENANCE RATES FOR CHILDREN AGES 2, 9, AND 16

State	Age 2			Age 9			Age 16			Clothing allowance included in basic rate (1989)
	1987	1988	1989	1987	1988	1989	1987	1988	1989	
Alabama	168	176	181	188	197	202	198	208	213	yes
Alaska	428	428	519	478	474	574	565	565	635	yes
Arizona	223	235	240	223	235	240	282	294	299	no
Arkansas	175	185	195	190	200	210	220	230	240	yes
California	294	294	*294	340	349	*340	412	412	*412	yes
Colorado	235	244	284	266	275	284	318	327	338	yes
Connecticut	268	280	319	302	316	355	350	367	407	yes
Delaware	264	273	284	266	276	286	342	354	369	yes
District of Columbia	304	304	307	304	304	307	317	356	321	yes
Florida	233	256	286	233	256	286	293	322	360	yes
Georgia	300	300	300	300	300	300	300	300	300	yes
Hawaii	194	194	504	233	233	504	301	301	504	no
Idaho	138	138	208	165	165	230	204	204	308	no
Illinois	233	245	257	259	272	286	282	296	311	yes
Indiana	226	*242	268	245	*272	312	280	*319	369	yes
Iowa	159	168	177	201	213	222	285	270	279	no
Kansas	187	195	205	245	264	277	280	334	351	no
Kentucky	248	250	250	263	266	266	300	304	304	yes
Louisiana	199	199	234	232	232	267	265	265	300	yes
Maine	244	253	269	250	260	276	291	302	321	no
Maryland	285	375	460	285	375	460	303	392	477	yes
Massachusetts	362	410	410	362	410	410	433	486	436	no

Michigan	315	300	347	315	300	347	395	376	433	yes
Minnesota	285	294	308	285	294	308	375	380	399	no
Mississippi	130	145	145	150	165	165	160	175	175	yes
Missouri	174	174	182	212	212	222	232	232	244	yes
Montana	283	283	288	283	283	288	354	354	361	no
Nebraska	210	222	222	210	222	222	210	222	222	no
Nevada	275	281	281	275	281	281	330	337	337	no
New Hampshire	200	200	200	251	251	251	354	354	354	yes
New Jersey	203	213	213	215	226	226	253	266	266	no
New Mexico	236	291	258	247	288	270	259	315	281	yes
New York	312	324	339	375	389	407	434	450	471	no
New York City	342	355	371	403	418	505	465	483	505	no
North Carolina	215	215	215	215	215	215	215	215	215	yes
North Dakota	240	240	250	287	287	300	345	345	400	yes
Ohio	*240	*247	*237	*270	*278	*246	*300	*251	*290	yes
Oklahoma	300	300	300	360	360	360	420	420	420	yes
Oregon	200	204	212	234	238	248	316	322	335	yes
Pennsylvania	558	*280	*291	558	*294	*323	558	*342	*354	no
Rhode Island	223	243	232	223	243	232	275	281	284	yes
South Carolina	138	152	182	158	174	209	208	229	275	yes
South Dakota	188	193	220	230	237	270	276	285	325	yes
Tennessee	139	188	213	190	191	213	224	231	250	yes
Texas	243	330	330	243	330	330	274	330	330	yes
Utah	198	198	240	198	198	240	225	225	240	yes
Vermont	210	270	*353	249	270	*353	268	324	*426	yes
Virginia	193	217	228	244	254	267	309	321	337	yes

TABLE 7.—FOSTER CARE BASIC MONTHLY MAINTENANCE RATES FOR CHILDREN AGES 2, 9, AND 16—Continued

State	Age 2			Age 9			Age 16			Clothing allowance included in basic rate (1989)
	1987	1988	1989	1987	1988	1989	1987	1988	1989	
Washington	184	188	215	227	231	265	268	273	313	yes
West Virginia	161	161	161	202	202	202	242	242	242	no
Wisconsin	163	163	163	224	224	224	284	284	284	yes
Wyoming	300	300	300	300	300	300	330	330	330	no
Average monthly rate	239	246	268	263	269	292	307	315	338	(yes=35 States)

*Average rate—all other rates are base rates.

Source: American Public Welfare Association.

TABLE 8.—REIMBURSEMENT RATE POLICIES FOR SPECIAL POPULATIONS, JULY 1989

State	HIV+/ AIDS	Drug addicted infants	Relative reimbursement	Day care reimbursement	Liability damages
Alabama	N	N	Y	Y	N
Alaska	N	N	Y	N	Y
Arizona	Y	N	Y	N	Y
Arkansas	N	N	N	N	N
California	Y	Y	Y	N	Y
Colorado	N	N	Y	N	N
Connecticut	Y	N	Y	N	N
Delaware	Y	N	N	N	N
District of Columbia	N	N	Y	N	N
Florida	Y	Y	Y	N	Y
Georgia	Y	N	Y	Y	Y
Hawaii	N	N	Y	N	Y
Idaho	Y	Y	Y	Y	Y
Illinois	N	N	Y	Y	Y
Indiana	N	N	Y	N	Y
Iowa	N	N	Y	N	Y
Kansas	N	N	Y	N	Y
Kentucky	Y	Y	Y	Y	Y
Louisiana	N	N	Y	Y	Y
Maine	Y	Y	Y	N	Y
Maryland	Y	Y	Y	Y	Y
Massachusetts	N	N	Y	N	Y
Michigan	N	N	Y	Y	N
Minnesota	N	N	Y	N	N
Mississippi	N	N	Y	N	N
Missouri	N	N	Y	Y	Y
Montana	N	N	Y	N	N
Nebraska	N	N	Y	N	N
Nevada	Y	Y	Y	N	Y
New Hampshire	N	N	Y	N	Y
New Jersey	Y	N	Y	Y	Y
New Mexico	Y	N	Y	N	Y
New York	Y	N	Y	Y	N
North Carolina	N	N	Y	Y	N
North Dakota	N	N	Y	N	Y
Ohio	N	N	Y	N	N
Oklahoma	N	N	Y	N	N
Oregon	N	N	Y	N	Y
Pennsylvania	N	N	Y	N	N
Rhode Island	Y	N	Y	Y	N

TABLE 8.—REIMBURSEMENT RATE POLICIES FOR SPECIAL POPULATIONS, JULY 1989—Continued

State	HIV+/AIDS	Drug addicted infants	Relative reimbursement	Day care reimbursement	Liability damages
South Carolina	Y	Y	Y	N	Y
South Dakota	N	N	Y	N	N
Tennessee	Y	N	Y	N	Y
Texas	N	N	N	N	N
Utah	N	N	Y	Y	Y
Vermont	N	N	Y	N	N
Virginia	N	N	Y	N	N
Washington	N	N	N	N	Y
West Virginia	Y	N	Y	N	Y
Wisconsin	N	N	Y	N	Y
Wyoming	N	N	N	N	N
Yes States	18	8	46	14	29

Y=yes; N=no.

Source: American Public Welfare Association.

The 1980 legislation also stipulated that title IV-E foster care payments may be made for children in public institutions, whereas previously under title IV-A payments were limited to children in private nonprofit institutions or foster family homes. These public institutions may accommodate up to 25 children. Facilities operated primarily for the detention of delinquents, including forestry camps and training schools, are noneligible institutions. It is generally agreed that the costs associated with institutional care are substantially higher than the cost of family foster care. The North American Council on Adoptable Children (NACAC) estimates the daily costs associated with basic family foster care to be $8 to $15, (up to $30 for a child with special needs). Comparatively, residential foster care is estimated on average to cost $100 a day per child (see table 9).

TABLE 9.—ESTIMATED DAILY RATES FOR COSTS OF OUT-OF-HOME CARE, 1990

Categories of care	Daily rate
Basic family foster care	$8–15
Specialized foster care (supplemental payments for care of children with physical or mental disabilities)	15–30
Therapeutic foster care	40
Residential foster care	100
Hospital placement	300

Source: Based on information supplied by the North American Council on Adoptable Children (NACAC).

Exclusion of foster children from AFDC assistance units

The Deficit Reduction Act of 1984 (P.L. 98-369) required that certain blood-related, adoptive parents or siblings must be included in the family unit if the family applies for income assistance under the AFDC program. Because there was no statutory exclusion for foster care recipients, AFDC operating policy required that their income be included with the family's when the family's eligibility was determined. Enacted in 1986 by Public Law 99-514, section 478 stated that a foster child who is receiving maintenance payments funded under title IV-E may not be considered a family member during the time the family receives AFDC, and that the child's income in the form of maintenance payments and other income and resources must be excluded from the family's as well.

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) repealed section 478 and added a new section 408 to title IV-A stipulating that foster children receiving maintenance payments under title IV-E or under State or local programs are not considered family members for purposes of AFDC. Similarly, the law now specifies that children receiving adoption assistance payments under either title IV-E or State or local law are not considered family members for AFDC purposes, unless the family would lose benefits as a result.

THE TITLE IV-E INDEPENDENT LIVING PROGRAM

In 1986, title IV-E was amended by Public Law 99-272 (Consolidated Omnibus Budget Reconciliation Act of 1985) to include section 477, which established the independent living program to assist youth who would eventually be emancipated from the foster care system. Several surveys conducted during the mid-1980s showed that a significant number of homeless shelter users had been recently discharged from foster care. The program's services were designed to assist adolescent youth who are not provided the benefits believed to come from reunification with their original family, or placement in an adoptive home.

In a 1981 article in "Children and Youth Sciences Review," researchers Hornby and Collins estimated that fewer than 20 percent of foster care adolescents will be reunified with their parents, and that fewer than 1 in 20 is likely to be adopted. According to the Department of HHS, nearly 75,000 youths were eligible for the independent living program in 1990. About 44,365 actually participated. (See table 10 for State-by-State data).

An annual entitlement amount of $45 million was established for 1987 and 1988 to provide States with the resources to establish and implement services to assist AFDC-eligible children age 16 and over make a successful transition from foster care to independent adult living when they become ineligible for foster care maintenance payments at age 18. The same amount was made available the following year and the program was expanded under Public Law 100-647. States could now provide independent living services to all youth in foster care aged 16 to 18 (not just title IV-E-eligible youth) and States could claim followup services provided to youth up to 6 months after their emancipation from substitute care. Under Public Law 101-508, States now have the option of serving individuals up to age 21 in the independent living program. Funds are allocated on the basis of each State's relative share of children receiving IV-E foster care in 1984.

Public Law 101-239 increased the amount of Federal entitlement funds available to the States for the independent living program to $50 million for fiscal year 1990, $60 million for fiscal year 1991, and $70 million for fiscal year 1992. Beginning in fiscal year 1991, States are required to provide 50 percent matching for any Federal funding claimed that exceeds the original $45 million funding level.

Section 477 of title IV-E also instructed HHS to carry out a study of the program's effectiveness. Under contract with HHS, Westat, Inc. completed the first phase of the study in 1989. This phase is a purely descriptive assessment of the needs of youth emancipated from foster care between January 1, 1987 and July 31, 1988; States' development of independent living programs to serve these youth; and the proportion of youth served.

The report found that independent living services offered by the States generally fall into the following categories: basic skills training (including health promotion, housekeeping, money management, decisionmaking, and food and nutrition management); education initiatives (including private tutoring, and GED and college preparation); and employment initiatives (including job training and placement, and personal presentation and social skills). In addition, 14 States currently hold teen conferences designed to bring these foster care youth together for workshops to provide them with supportive contacts, teach them independent living skills, focus on self-esteem building, and help prepare them for their impending emancipation from foster care.

The report concluded that emancipated youth were a troubled population. In the study population, two-thirds of 18-year-olds did not complete high school or a GED and 61 percent had no job experience. In addition, 38 percent had been diagnosed as emotionally disturbed, 17 percent had a drug abuse problem, 9 percent had a health problem, and 17 percent of the females were pregnant. The group also lacked placement stability. During the time they were in foster care 58 percent experienced at least three living arrangements and approximately 30 percent of the youth had been in substitute care for an average of 9 years. The report found evidence that Public Law 99-272 has influenced States to develop policies for services that adolescents should receive before their emancipation from foster care. Of the 49 States that responded, 22 had such a written policy before the law was enacted. By 1988, when the study was concluded, an additional 18 States had initiated the process of developing similar policies. (By 1990, all States had an independent living program plan).

Of the total 34,600 youth emancipated from foster care during the study period, 31 percent received services through their State's formalized independent living program, 29 percent received nonformalized (but related) services, and 40 percent received no independent living services at all.

The second phase of the report is scheduled for completion during the first half of 1991. In order to determine program effectiveness it will compare the previously identified group of adolescents that received services with a control group that did not on a number of outcome measurements.

TABLE 10.—FOSTER CARE INDEPENDENT LIVING PROGRAM—FISCAL YEAR 1990 SERVICES IN PLANS, NUMBER OF CHILDREN, AND FEDERAL AWARDS

State	Educational/ vocational training	Daily living skills	Individual and group counseling	Coordination of services	Outreach programs	Transition plan	Other services	Eligible children	Children participating	Actual Federal awards
Alabama	X	X	X	X	X	X	X	914	640	$741,779
Alaska	X	X	X			X		350	15	9,309
Arizona	X	X	X	X	X	X	X	414	243	248,403
Arkansas	X	X	X	X		X		424	367	193,529
California	X	X	X	X	X	X	X	18,768	6,000	8,915,552
Colorado	X	X	X	X	X	X	X	1,060	440	589,895
Connecticut	X	X	X	X	X	X		700	275	538,941
Delaware	X	X				X		175	80	145,024
District of Columbia	X	X	X			X		386	140	779,995
Florida	X	X	X	X	X	X	X	2,055	1,589	705,033
Georgia	X	X	X	X	X		X	1,937	750	784,894
Hawaii	X	X	X			X	X	200	45	12,739
Idaho	X	X	X	X	X	X	X	161	161	76,432
Illinois	X	X	X	X	X	X	X	3,734	2,000	2,012,209
Indiana	X	X	X	X		X		1,305	1,053	728,550
Iowa	X	X	X	X	X	X	X	1,268	1,268	321,405
Kansas	X	X	X	X	X		X	1,500	1,500	512,484
Kentucky	X	X	X	X	X	X	X	1,400	500	565,398
Louisiana	X	X		X	X	X		1,042	521	970,094
Maine	X	X	X	X	X	X	X	375	150	404,206

Maryland	X	X	X	X	X	X	X	1,036	1,036	884,353
Massachusetts		X	X			X	X	1,536	1,536	454,180
Michigan	X	X	X	X	X	X	X	3,902	3,902	2,979,853
Minnesota	X	X	X	X		X	X	1,500	1,500	815,761
Mississippi	X	X	X	X		X		552	296	367,460
Missouri	X	X	X	X		X		1,000	220	925,019
Montana	X	X	X	X	X	X	X	357	125	174,421
Nebraska		X	X	X				1,000	500	311,116
Nevada	X	X	X	X		X	X	340	340	109,748
New Hampshire	X	X	X		X	X		476	318	228,805
New Jersey	X	X	X	X	X	X		1,535	1,535	1,641,320
New Mexico	X	X	X	X	X	X	X	50	50	147,964
New York	X	X				X	X	4,571	4,571	8,275,682
North Carolina	X	X	X	X	X	X	X	633	725	746,678
North Dakota	X	X	X	X	X	X	X	282	282	137,185
Ohio	X	X	X	X	X	X	X	2,700	2,700	2,043,566
Oklahoma	X	X		X	X	X	X	404	331	442,911
Oregon	X	X	X	X		X	X	1,800	828	664,857
Pennsylvania	X	X	X	X		X		3,800	1,000	3,313,017

TABLE 10.—FOSTER CARE INDEPENDENT LIVING PROGRAM—FISCAL YEAR 1990 SERVICES IN PLANS, NUMBER OF CHILDREN, AND FEDERAL AWARDS—Continued

State	Educational/ vocational training	Daily living skills	Individual and group counseling	Coordination of services	Outreach programs	Transition plan	Other services	Eligible children	Children participating	Actual Federal awards
Rhode Island		X	X	X	X	X		645	100	224,885
South Carolina	X	X	X	X	X	X	X	425	340	414,005
South Dakota	X	X	X	X	X	X	X	100	75	138,165
Tennessee	X	X	X	X	X	X	X	1,386	736	555,599
Texas	X	X	X	X	X	X	X	594	450	1,315,504
Utah	X	X	X	X	X	X	X	441	215	144,534
Vermont		X				X		347	200	211,167
Virginia	X	X				X	X	1,471	1,176	972,543
Washington	X	X	X	X	X	X	X	1,300	300	589,405
West Virginia	X	X	X		X	X		850	391	372,359
Wisconsin	X	X	X	X	X	X	X	1,664	800	1,110,218
Wyoming	X	X	X	X	X	X	X	85	50	31,847
Total	47	51	45	41	34	48	35	74,950	44,365	50,000,000

Note: The information in this table is based on State plans. According to these State plans, 44,365 children will participate in Independent Living Program activities at some time during fiscal year 1990.

Source: Department of Health and Human Services, Office of HDS, ACYF.

THE TITLE IV-E ADOPTION ASSISTANCE PROGRAM

The title IV-E adoption assistance program is an open-ended entitlement program required of States that participate in AFDC (all States participate). The program is permanently authorized under title IV-E and allows States to develop adoption assistance agreements with parents who adopt eligible children with special needs. Federal matching funds are provided to States that, under these agreements, provide adoption assistance payments to parents who adopt AFDC- or SSI-eligible children with special needs. In addition, the program authorizes Federal matching funds for States that reimburse the nonrecurring adoption expenses of adoptive parents of special needs children (regardless of AFDC or SSI eligibility).

Definition of special needs

A special needs child is defined in the statute as a child with respect to whom the State determines there is a specific condition or situation, such as age, membership in a minority or sibling group, or a mental, emotional, or physical handicap, which prevents placement without special assistance. Before a child can be considered to be a child with special needs, the State must determine that the child cannot or should not be returned to the biological family, and that reasonable efforts have been made to place the child without providing adoption assistance. States have considerable latitude in defining special needs eligibility criteria and individually determining whether a child is eligible. For example, some States add religion or not being able to place the child without subsidy to the definition of special needs.

Adoption assistance agreements and payments

An adoption assistance agreement is a written agreement between the adoptive parents, the State IV-E agency, and other relevant agencies (such as a private adoption agency) specifying the nature and amount of assistance to be given. Under the adoption assistance agreement, States may make monthly adoption assistance payments for AFDC- and SSI-eligible children with special needs who are adopted.

Adoption assistance payments are based on the circumstances of the adopting parents and the needs of the child. No means test can be used to determine eligibility of parents for the program; however, States do use means tests to determine the amount of the payment. Payments may be adjusted periodically if circumstances change, with the concurrence of the adopting parents. However, the payments may not exceed the amount the family might have received on behalf of the child under AFDC foster care for foster family care. Adoption assistance payments may continue until the child is age 18, or, at State option, age 21 if the child is mentally or physically handicapped. In addition, payments are discontinued if the State determines that the parents are no longer legally responsible for the support of the child. Federally subsidized payments may start as soon as an agreement is signed and the child has been placed in an adoptive home. Parents who have been receiving adoption assistance payments must keep the State or local agency informed of circumstances that would make them ineligible for payments, or eligible for payments in a different amount.

The Federal matching rate for the adoption assistance payments is based on each State's medicaid matching rate (which ranges from 50 to 83 percent depending on State per capita income, and averages about 53 percent nationally). States may also claim open-ended Federal matching for the costs of administering the program (50 percent) and for training both staff and adoptive parents (75 percent).

Not all families of adopted IV-E eligible children with special needs actually receive adoption maintenance payments. (The adoptive parents' circumstances may be such that an adoption subsidy is not needed or wanted.) Adopted AFDC or SSI eligible children with special needs are also eligible for medicaid if an adoption assistance agreement is in effect, whether or not adoption assistance payments are being made. Therefore, there are some IV-E eligible children with special needs for whom adoption maintenance payments are not made but who are eligible for medicaid.[4]

The structure of adoption subsidy programs varies across States. Some States offer basic maintenance payments and also allow additional payments for certain activities (such as family counseling) or groups of children (such as children with severe handicaps). Other States offer one level of payment to everyone with no special allowances. Some States allow parents to request changes in payment levels on a regular basis if circumstances change for a child, and others allow very little change once the adoption agreement is signed. Some States start payments as soon as placement is made, and others not until the adoption is finalized. Also, payments may not start immediately upon adoption finalization but may be written into agreements to start at a later date if it is thought that the child's circumstances will warrant payments as the child gets older.

Not all children who receive adoption subsidies from States are eligible for Federal IV-E funds. The American Public Welfare Association (APWA) estimates that at the end of 1987 (the latest year for which data are available), approximately 51 percent or 33,000 of the 65,000 children whose families received adoption subsidies were IV-E eligible.[5] The non-IV-E children's adoption subsidies are paid solely by the State in which their adoption agreement was signed. States differ in whether comparable IV-E children and non-IV-E children receive similar adoption subsidy amounts.

Nonrecurring adoption costs

The adoption assistance program also authorizes Federal matching funds for States that pay the onetime adoption expenses of parents of special needs children (regardless of AFDC or SSI eligibility). To qualify, the children must be covered by an adoption assistance agreement. Effective January 1, 1987, parents may receive reimbursement of up to $2,000 for these nonrecurring adoption expenses under the adoption assistance program, and States may claim 50 percent Federal matching for these payments. Qualified adoption expenses are defined as reasonable and necessary adoption fees, court costs, attorney fees, and other expenses which are directly related to the legal adoption of a child with special needs. States vary in the maximum amount they allow parents to receive under this provision, and not all States currently provide this reimbursement. (See table 11 for State-by-State data on maximum reimbursement rates.) Regulations for the program were not published until 1988. Prior to January 1987, up to $1,500 of nonrecurring costs of adopting a child with special needs could be claimed as a tax deduction. The 1986 tax reform legislation repealed the adoption expense deduction.

---

[4] States also have the option under the medicaid program to provide medicaid coverage for other special needs children (those not eligible for AFDC or SSI) who are adopted if they have been identified as a special category of medically needy children under a State's medicaid program. Pursuant to the 1985 budget reconciliation legislation, effective October 1, 1986, a child for whom an adoption assistance agreement is in effect is eligible for medicaid from the State in which the child resides regardless of whether the State is the one with which the adoptive parents have an adoption assistance agreement.

[5] These data are based on reports by 26 States.

TABLE 11.—REIMBURSEMENT FOR NONRECURRING ADOPTION COSTS

State	Maximum rate	Average paid (if known)
Alabama	$1,000	
Alaska	2,000	$1,200
Arizona	[2,3] 2,000	
Arkansas	1,500	
California	400	
Colorado	800	
Connecticut	750	
Delaware	[3] 2,000	
District of Columbia	[3] 2,000	
Florida	1,000	
Georgia	700	
Hawaii	2,000	
Idaho	(1)	
Illinois	1,500	1,000
Indiana	1,500	850
Iowa	(1)	500
Kansas	2,000	
Kentucky	1,000	500
Louisiana	350	320
Maine	2,000	
Maryland	[3] 2,000	
Massachusetts	(1)	
Michigan	(1)	
Minnesota	2,000	
Mississippi	1,000	
Missouri	[3] 2,000	
Montana	[2,3] 2,000	

TABLE 11.—REIMBURSEMENT FOR NONRECURRING ADOPTION COSTS—Continued

State	Maximum rate	Average paid (if known)
Nebraska	2,000	
Nevada	250	
New Hampshire	2,000	
New Jersey	(1)	
New Mexico	2,000	
New York	2,000	500
North Carolina	(1)	
North Dakota	(1)	300
Ohio	2,000	
Oklahoma	2,000	
Oregon	2,000	1,300
Pennsylvania	2,000	
Rhode Island	(1)	
South Carolina	1,500	750
South Dakota	1,500	650
Tennessee	2,000	700
Texas	1,500	
Utah	2,000	
Vermont	2,000	
Virginia	2,000	
Washington	1,500	
West Virginia	(1)	
Wisconsin	2,000	500
Wyoming	(2)	
Average	1,604	698

[1] State has not implemented the reimbursement program.

[2] Legislation is necessary to authorize reimbursement of adoptive parents.

[3] Amount indicated is the proposed maximum reimbursement; State has not implemented the program to date.

Source: American Public Welfare Association (APWA), Association of Administrators of the Interstate Compact on Adoption and Medical Assistance, Inc.

Adoption assistance expenditures

The number of children on whose behalf monthly adoption assistance payments are made and the Federal expenditures for these payments have increased significantly since the program began. In fiscal year 1981, only 6 States participated in the program, with payments being made for an average of 165 children per month. In fiscal year 1991, 50 States plus the District of Columbia will participate, and will serve an estimated average monthly number of 49,970 children[6] (see table 12).

---

[6] Data on the Federal expenditures, State claims, and average number of children associated with the adoption assistance program are provided by the U.S. Department of Health and Human Services (HHS).

TABLE 12.—ADOPTION ASSISTANCE STATE CLAIMS, FISCAL YEARS 1988–91, AND ESTIMATED AVERAGE NUMBER OF CHILDREN RECEIVING ADOPTION ASSISTANCE, FISCAL YEAR 1991

[Dollars in thousands]

State	Fiscal year—				
	1988 claims	1989 claims	1990 claims (est.)	1991 claims (est.)	1991 estimated average monthly number of children
Alabama	$238	$302	$355	$429	200
Alaska	57	99	149	180	50
Arizona	766	998	1,186	1,435	399
Arkansas	376	1,051	497	601	205
California	12,123	15,306	19,778	23,922	6,349
Colorado	424	717	844	1,021	299
Connecticut	990	1,041	1,158	1,401	294
Delaware	132	226	259	313	130
District of Columbia	767	510	741	896	250
Florida	3,396	4,908	5,705	6,900	1,788
Georgia	639	886	1,035	1,252	659
Hawaii	29	60	91	110	37
Idaho	134	130	319	386	116
Illinois	3,433	4,063	4,710	5,697	2,512
Indiana	896	1,195	1,738	2,102	704
Iowa	365	549	1,096	1,326	558
Kansas	359	409	512	619	626
Kentucky	790	1,718	2,056	2,487	590
Louisiana	717	1,061	1,529	1,849	568
Maine	573	792	986	1,193	361
Maryland	790	1,082	1,035	1,252	394
Massachusetts	973	1,405	3,472	4,199	790
Michigan	9,356	10,587	12,522	15,146	4,682
Minnesota	791	891	1,061	1,283	496
Mississippi	380	378	355	429	247
Missouri	1,618	1,651	1,688	2,042	1,124
Montana	139	138	185	224	85
Nebraska	442	510	673	814	360
Nevada	56	112	167	202	40
New Hampshire	134	189	237	287	246
New Jersey	3,876	2,926	3,458	4,183	1,638
New Mexico	692	701	1,183	1,431	398
New York	28,640	28,393	34,752	42,033	9,341
North Carolina	538	655	726	878	961
North Dakota	145	167	184	223	85

TABLE 12.—ADOPTION ASSISTANCE STATE CLAIMS, FISCAL YEARS 1988–91, AND ESTIMATED AVERAGE NUMBER OF CHILDREN RECEIVING ADOPTION ASSISTANCE, FISCAL YEAR 1991—Continued

[Dollars in thousands]

State	Fiscal year—				
	1988 claims	1989 claims	1990 claims (est.)	1991 claims (est.)	1991 estimated average monthly number of children
Ohio	9,009	9,051	11,374	13,757	3,784
Oklahoma	326	882	1,061	1,283	270
Oregon	396	622	939	1,136	590
Pennsylvania	1,683	2,660	2,928	3,542	1,276
Rhode Island	2,153	2,869	3,016	3,648	514
South Carolina	922	1,117	1,602	1,938	421
South Dakota	362	628	54	65	176
Tennessee	584	1,000	1,354	1,638	546
Texas	1,591	2,240	4,330	5,237	1,762
Utah	266	363	339	410	129
Vermont	486	933	1,156	1,398	247
Virginia	875	809	1,075	1,300	600
Washington	686	656	751	908	831
West Virginia	218	212	196	237	56
Wisconsin	2,438	3,269	3,776	4,567	1,170
Wyoming	33	58	65	79	25
Total	97,602	113,175	140,458	169,888	49,970

Federal expenditures for the assistance payments portion have increased from less than $400,000 in fiscal year 1981 to an estimated $129 million in fiscal year 1991, and are expected to be $154 million in fiscal year 1992. Federal expenditures for the nonrecurring adoption expenses portion are expected to be $2.7 million in fiscal year 1991 and $3 million in fiscal year 1992. An estimated 44,000 children were the beneficiaries of the adoption assistance provision in fiscal year 1990.

U.S. Department of Health and Human Services (HHS) data indicate that expenditures for child placement services and administration for the adoption assistance program have increased significantly during the last 10 years, as with the title IV–E foster care program. In fiscal year 1981, claims totaled $100,000; in fiscal year 1991 they will total an estimated $39 million and are expected to be $45 million in fiscal year 1992. States may claim matching funds for the following placement service and administrative activities: recruitment of adoptive homes, placement of the child in the adoptive home, home studies of the prospective adoptive home, case planning, case management, and case review activities during the preadoptive period.

Characteristics of Children in Adoptive Care[7]

National data on the characteristics of children for whom adoption assistance payments are made are not available. However, APWA's Voluntary Cooperative Information System (VCIS) is the primary source of data on the national child welfare system, and publishes the only comprehensive data estimates on the adoption of special needs children who at some time have been part of the substitute care system.[8] Not all of the children described in VCIS data are the beneficiaries of adoption subsidies. VCIS collects information from States and compiles it in an annual report, with data available from fiscal years 1982 through 1987. APWA notes that the data in its reports should be treated as rough estimates given the voluntary nature of the information, and the fact that not all States report data on all questions, or conform to the same data definitions.[9]

VCIS collects information on adoptions related to substitute care children only. VCIS divides children in adoptive care into those with finalized adoptions, awaiting adoptive placement, or residing in nonfinalized adoptive homes. Children in the latter two categories are included in VCIS's definition of substitute care. VCIS collects data on the age, race/ethnicity, special needs status, and relation to adoptive parents of these children. The numbers below represent national estimates that APWA calculated based on data received from reporting States. Not all of the children described below were adopted with subsidies.

VCIS reported that 18,000 to 20,000 children had a finalized adoption in fiscal year 1987, and 15,000 to 17,000 were placed in a nonfinalized adoptive home. Another 17,000 to 19,000 were still in substitute care and awaiting adoptive placement at the end of fiscal year 1987. Of the adoptions that were finalized in fiscal year 1987, the 2 largest age groups of children were between 1 and 5 years of age (45.6 percent) and between 6 and 12 years of age (37.7 percent). The median age of children whose adoptions were finalized was 4.8 years. The majority of children (58.6 percent) were white, while 27.7 percent were black. Fifty-three percent of these children had one or more special needs that could pose barriers to adoption (see table 13).

---

[7] Children in adoptive care have had a finalized adoption, are in a nonfinalized adoptive home, or are awaiting adoptive placement.

[8] Substitute care is defined as a living arrangement in which children are residing outside of their own homes under the case management and planning responsibility of the primary State child welfare agency or of child placing agencies under contract to the primary agency. Living arrangements can include foster family or adoptive foster homes (both relative and nonrelative), group homes, child care facilities, emergency shelter, supervised independent living, nonfinalized adoptive home placements, and all other arrangements regarded as 24-hour substitute care by the State agency.

[9] Two efforts are underway to address the lack of comprehensive data on adoption and the adoption assistance program in particular. "The Adoption Assistance Impact and Outcome Study" is a 3-year national study by the Administration for Children, Youth, and Families (ACYF), HHS, conducted by Westat, Inc. This study, which began in 1989, will involve a number of different components including an extensive survey of State adoption assistance programs and a survey of parents and children who have adopted with subsidies. The study will analyze the role of adoption assistance in promoting special needs adoption and determine how the adoption process affects children and families. In addition, Federal legislation was passed in 1987 requiring the Secretary of HHS to develop a system for the uniform collection of data on adoption and foster care in the United States. The National Center for State Courts received a grant to assist ACYF establish the National Adoption Information System. This system will replace VCIS and become the primary source of data on all adoptions (public and private) in the United States.

Nearly half (47.4 percent) of the children whose adoptions were finalized in fiscal year 1987 were adopted by people completely unrelated to them. Another 44.5 percent of the children were adopted by nonrelative foster parents. Only 4.8 percent were adopted by relatives, and 3.3 percent were unknown.[10]

The composition of children awaiting adoptive placement is somewhat different from children whose adoptions were finalized.

TABLE 13.—FINALIZED ADOPTIONS AND CHILDREN AWAITING ADOPTIVE PLACEMENT, FISCAL YEAR 1987

[In percentages]

	Finalized adoptions [1]	Children awaiting adoptive placement [2]
Age:		
0 to 1 year	[3] 6.5	[4] 2.3
1 to 5 years	45.6	31.7
6 to 12 years	37.7	45.6
13 to 18 years	9.9	19.5
19 years and older	.2	.6
Unknown	.1	.1
Race/ethnicity:		
White	[5] 58.6	[6] 52.5
Black	27.7	34.1
Hispanic	8.1	9.0
Other	4.4	3.3
Unknown	1.2	1.1
Special needs status:		
1 or more special needs	[7] 53.0	[8] 65.5
No special needs	46.3	31.9
Unknown	.7	2.6
Time awaiting adoptive placement:[9]		
0 to 6 months		26.2
6 to 12 months		11.5
1 to 2 years		19.7
2 years or more		40.6
Unknown		2.1

[1] Data reported on the number of finalized adoptions which took place during fiscal year 1987.
[2] Data reported on the number of children awaiting placement at the end of fiscal year 1987.
[3] Data provided by 21 States.
[4] Data provided by 20 States.
[5] Data provided by 28 States.
[6] Data provided by 24 States.
[7] Data provided by 24 States.
[8] Data provided by 21 States.
[9] Data provided by 18 States.
Source: APWA, VCIS, 1987.

---

[10] These data were provided by 22 States.

These children are generally older (median age was 8.2 years versus 4.8 years for finalized children), and include a greater percentage of black children (34.1 percent versus 27.7 percent of finalized children). In addition, of the children awaiting adoptive placement, 40.6 percent had been waiting for 2 or more years (see table 13).

TABLE 14.—PROPORTION OF SPECIAL NEEDS CHILDREN IN FOSTER CARE, WAITING ADOPTION, AND ADOPTED, 1983 TO 1985

Status	1983	1984	1985
Number of children in foster care	269,000	276,000	276,000
(Percent with special needs)	22	22	18
Number of foster children waiting adoption	NA	17,000	16,000
(Percent with special needs)	NA	43	51
Number of foster children adopted	19,000	20,000	16,000
(Percent with special needs)	61	57	62

Source: "State Child Welfare Abstracts 1980–1985," Maximus Inc. prepared for Office of Social Services Policy, Assistant Secretary for Planning and Evaluation, HHS, December 1987.

PROTECTIONS FOR CHILDREN IN FOSTER CARE

The 1980 legislation changed the funding mechanisms for both the title IV–B child welfare services and the title IV–A foster care program (the latter program was transferred to the newly created title IV–E). These changes were intended to serve as incentives to States to use child welfare services in lieu of initial or continued foster care placement whenever possible and appropriate. Primary emphasis was placed on preventing the need for substitute care, and reuniting as many foster children as possible with their families.

Public Law 96–272 assumed increased appropriations for child welfare services but limited the amount of new title IV–B Federal funds States could spend until certain protections for children in foster care were implemented. The Act also included a provision allowing States to transfer money from their title IV–E foster care allotments to their title IV–B child welfare programs for specified services if certain requirements to protect children in foster care are met and maintained.

PROTECTIONS LINKED TO TITLE IV–B

Transfer of title IV–E foster care funds to title IV–B child welfare services

The 1980 legislation, as amended, established a mandatory ceiling on title IV–E foster care payments for each fiscal year if in any fiscal year appropriations for the title IV–B child welfare services program reach $325 million (increased from $266 million by Public Law 101–239, beginning with fiscal year 1990). With this ceiling in place, under certain conditions States may transfer any unused title IV–E foster care funds to use for any child welfare services under title IV–B. As is shown in table 15, the authorized and appropriated amount have not converged since the first year of the new legislation. In those years when appropriations do not reach the trigger amount, States may choose to operate under a voluntary ceiling and transfer a certain proportion of unused title IV-E foster care funds to their title IV-B child welfare services program.

TABLE 15.—TITLE IV-B APPROPRIATIONS AND AUTHORIZATIONS, FISCAL YEARS 1981-92

[In millions of dollars]

Fiscal year	Authorization	Appropriation	Difference
1981	$163.6	$163.6	$0.0
1982	220.0	156.3	63.7
1983	266.0	156.3	109.7
1984	266.0	165.0	101.0
1985	266.0	200.0	66.0
1986	266.0	[1] 198.1	67.9
1987	266.0	222.5	43.5
1988	266.0	239.4	26.7
1989	266.0	246.7	19.3
1990	325.0	[2] 252.6	72.4
1991	325.0	273.9	51.1
1992	[3] 363.9	[3] 363.9	0

[1] Reflects a 4.3 percent reduction in the $207 million IV-B child welfare funds appropriated, due to sequestration under the Gramm-Rudman-Hollings legislation.

[2] Reflects a 1.4 percent reduction in the $256.1 million in IV-B funds appropriated, due to sequestration under the Gramm-Rudman-Hollings legislation.

[3] Based on proposed legislation.

Source: Department of Health and Human Services.

Each year a State's ceiling is based on the greater of: (1) The fiscal year 1978 title IV-E foster care funding for the State with annual increases equivalent to either a 10 percent increase, or double the increase in the Consumer Price Index (CPI) (whichever is less); or (2) a share of $100 million based on the number of the State's population under the age of 18.

In a year in which the title IV-B trigger amount is appropriated (only 1981), and the mandatory title IV-E payment ceiling goes into effect, a State could chooses to have its ceiling based on one-of-two options: (a) the higher of the above (1) or (2), or (b) the 1978 funding level increased by the amount of the AFDC foster care caseload increase since 1978 if the State's caseload (relative to its total child population) was lower that the 1978 national average.

When operating under such a mandatory ceiling, States—except those choosing to operate under the alternative formula (B above)—may use matching foster care funds for the title IV-B child welfare services at the Federal matching rate of 75 percent. Although this is the technical matching rate, States are allowed to use their foster care maintenance funds to meet the non-Federal matching requirement (in effect this means that the receipt of new Federal funds does not require any increase in State matching funds). These transferred funds may not exceed the State's allotment of $141 million unless certain preplacement preventive services are implemented.

If the title IV–B appropriation equals or exceeds $325 million (increased from $266 million by P.L. 101–239, beginning in fiscal year 1990) for 2 consecutive years, a State cannot transfer funds from title IV–E to title IV–B unless all the foster care procedures and protections required for receipt of the title IV–B incentive funds (including preplacement prevention services) are implemented. However, since the law's inception in 1981, authorization and appropriation levels have only converged in that first year.

If a State chooses to adopt a voluntary ceiling, it may transfer funds up to the point which, if the amount is added to this title IV–B allocation, does not exceed what it would have received if the title IV–B appropriation had been adequate to trigger the mandatory ceiling on title IV–E expenditures. In addition, the amount transferred when added to the State's title IV–B allocation, may not exceed its allotment of the $141 million title IV–B funds unless certain foster care procedures and protections specified in the 1980 legislation are implemented. If for any 2 fiscal years the amount of money transferred added to direct title IV–B funds equals the transfer funds unless it has implemented all the foster care procedures and protections, as specified in the 1980 legislation as those necessary for the receipt of additional child welfare services funds, including preplacement prevention services.

States have had the option of operating under a voluntary ceiling since fiscal year 1982. However, under this agreement the total amount of money being transferred by the States from title IV–E to title IV–B had been steadily decreasing since 1983 (see table 16). During that year, 24 States participated, transferring a total of $32.6 million. In 1989, six States transferred a total of $1.6 million. In 1990, five States transferred a total of $5.3 million; however, the amount transferred is again expected to drop to $1 million in 1991 (see following table).

TABLE 16.—NUMBER OF STATES TRANSFERRING FUNDS FROM TITLE IV–E TO IV–B AND THE TOTAL AMOUNT TRANSFERRED, FISCAL YEARS 1982–92

Fiscal year	Number of States participating	Total amount of transfers (in millions)
1982	24	$20.6
1983	31	32.6
1984	23	32.2
1985	22	19.6
1986	16	14.9
1987	15	11.3
1988	10	5.1
1989	[1] 6	1.6
1990	5	5.3
1991 (estimate)	NA	1.0
1992 (estimate)	NA	1.0

[1] Alabama, Hawaii, Idaho, Indiana, Kansas, and Mississippi.

Source: Department of Health and Human Services.

Foster care protections linked to title IV–B child welfare services funding

To encourage States to use their allocations to fund services to help keep families together and prevent the placement of children in substitute care with their child welfare services money, the legislation requires that if the title IV–B appropriation exceeds the Federal appropriation in 1979 ($56.5 million) States may not use any of these funds in excess of their allocation of $56.5 million for foster care maintenance payments, adoption assistance, or work-related child care. Appropriations for title IV–B have consistently exceeded this amount.

In addition, if the appropriation for the title IV–B program exceeds $141 million in any year, States are not eligible for any of their allotment above this amount unless certain protections have been implemented: (1) a one-time inventory of children in foster care more than 6 months, to determine the appropriateness of (and necessity for) the current foster care placement, whether the child should be returned to his parents or freed for adoption, and the services necessary to achieve this placement goal; (2) a statewide information system from which the status, demographic location, and placement goals of every child in care for the preceding 12 months can be determined; (3) a case review system to assure procedural safeguards for each child in foster care, including a 6-month court or administrative review and an 18-month dispositional hearing to assure placement in a setting that is the least restrictive (most family-like) setting available, in close proximity to the original home, and in the best interest of the child; (4) a reunification program to return children to their original homes. These provisions are contained in section 427 of the act.

In addition to the procedures specified above, States must implement a preplacement prevention service program if the title IV–B appropriation amount is $325 million (increased from $266 million by Public Law 101–239) for 2 consecutive years. If all these procedures and programs are not implemented by a State, its allotted amount of title IV–B funds is reduced to its share of the $56 million it received in fiscal year 1979. Through fiscal year 1991, the amount appropriated to title IV–B has never been sufficient to trigger this provision.

Since 1981, the annual appropriation levels for title IV–B have consistently exceeded $141 million. In fiscal year 1981, 34 States (including Puerto Rico) self-certified their eligibility for "incentive funds" (their allotment of funds in excess of $141 million). An additional 10 States self-certified their eligibility for fiscal year 1982.

Since that time State compliance with Federal standards has been reviewed by ACYF using case reviews of States' child welfare systems. These 427 reviews are conducted each year in a number of eligible States. In preparation for a review, a number of cases are selected from a State's caseload to determine its compliance with the required procedures and child protections stipulated in section 427 of title IV–B.

As of fiscal year 1990 40 States are in compliance, 1 State has self-certified and is awaiting ACYF review, 6 are not in compliance, and 2 are not self-certified, meaning that they have elected to forgo their allotment of title IV-B funding in excess of $141 million. In addition, 37 States currently exhibit the highest level of compliance eventually required of all States that wish to remain eligible for these funds. The compliance review process is described in greater detail later in this section.

As a result of legislation passed in the 101st Congress, a foster child's case record must now include his or her health and education records. Beginning in fiscal year 1990, the names and addresses of the child's health and educational providers must be recorded as well as the child's grade level performance, school record, and assurances that the child's placement takes into account the proximity of the school in which the child was enrolled at the time of placement. In addition, a record of the child's immunizations, known medical problems, required medications, and other relevant information must be included.

MANDATORY PROTECTIONS FOR FOSTER CHILDREN FUNDED UNDER TITLE IV-E

The 1980 legislation also strengthened the State plan eligibility requirements for title IV-E foster care or adoption assistance payments to emphasize protections for foster children originating from families eligible for AFDC at the time of placement. By law, for children receiving payments under the title IV-E State plan, States must establish: (1) by fiscal year 1984, specific goals as to the maximum number of children in care more than 24 months, and a description of the steps they will take to meet these goal; (2) a case plan review system to be conducted every 6 months on each child in foster care including:

—a written document describing the child's placement and its appropriateness;

—a plan, if necessary, for compliance with requirements made by judicial determination;

—a plan of services to be provided to improve family conditions and facilitate the reunification of the child with his or her family, or—if this is not possible—to provide for a permanent placement and/or otherwise serve the needs of the child during the time it is placed in foster care; and

(3) beginning in fiscal year 1984, that case plans must show that reasonable efforts have been made prior to placement to prevent the need for placement or to return the child home if removed. As of the same date, eligibility for Federal matching funds for cases involving a judicial placement requires a determination by the court that these efforts have been met.

The 1980 law also provided sanctions for noncompliance with these State plan requirements and mandated an independent audit of States' title IV-E programs (including adoption assistance) in an administrative review. Similar to title IV-B section 427 reviews, title IV-E administrative reviews must take place in each State at least once every 3 years. In addition, fiscal reviews of the standards and appropriateness of the costs associated with foster care and related services are conducted by the department periodically in each State.

"REASONABLE EFFORTS REQUIREMENT"

Public Law 96–272 includes the requirement that reasonable efforts must be made to prevent the placement of a child in foster care, and to reunify a foster child with his or her parents. The Social Security Act specifies the requirement in two separate provisions. First, in order for a State to be eligible for title IV–E funding, its State plan must specify that reasonable efforts will be made prior to the placement of a child in foster care to prevent the need for foster care and make it possible for the child to eventually return home (sec. 471 (a)(15)). Second, for each child entering foster care after October 1, 1983, a judicial determination must be made that there were reasonable efforts to prevent placement in substitute care (sec. 472(a)(1)).

A 1984 policy announcement issued by ACYF (ACYF–PA–84–1) and a subsequent Federal regulation issued by the Department in 1986 (45 CFR 1356–7), do not define the term "reasonable efforts"; instead this definition has been left to States. State compliance with Federal reasonable efforts provisions are audited in title IV–E reviews by HHS.

According to a 1987 American Bar association (ABA) publication by Debra Ratterman, G. Diane Dodson, and Mark A. Hardin, a total of 21 States had statutes addressing the judicial determination of reasonable efforts as of 1986. The ABA reports that States have continued to develop statutory guidelines since 1986. The ABA report found that State agencies also play a role in defining reasonable efforts through their interpretation of State court requirements to provide preplacement preventive services.

In addition to placement, adherence to reasonable effort is a requirement for the termination of parental rights in many States. For example, New York's statute specifies "diligent efforts," which require that prior to the termination of parental rights an authorized agency must: consult and cooperate with the parents of a child in developing a plan for the provision of appropriate services, make suitable arrangements for the parents to visit the child, provide services and other assistance to the parents, inform the parents at appropriate intervals of the child's health, and make suitable arrangements with a correctional facility if one of the parents if incarcerated and visiting with the child would be in the best interest of the child.

The interpretation of reasonable efforts varies substantially from State to State. According to the 1987 ABA report, the State of Florida defines reasonable efforts as "the exercise of ordinary diligence and care by the division." Definitions which go further also differ in fundamental ways. For example, Arkansas statutes state that "reasonable efforts means the exercise of reasonable diligence and care by the responsible State agency to utilize available services related to meeting the needs of the juvenile and the family," but the definition of reasonable effort in the State of Missouri "assumes the availability of a reasonable program of services to children and their families" (emphasis added).

However, there is anecdotal evidence that at least some jurisdictions are not interpreting the requirement in the best interest of the families and children it is designed to protect. Representatives of the A.B.A. report that in some cities the placement of children in foster care and the termination of parental rights is routinely ordered by court judges without reviewing (or in some cases requiring) documentation that reasonable efforts were adhered to by the placement agency. Because in these cases there is no review of agency practices, families that could benefit from preplacement prevention services may not receive them and children may be unnecessarily placed in foster care.

An assessment of the New York City Child Welfare administration conducted by the New York State department of Social Services and published in May, 1989, found that in a review of 46 cases in which placement occurred, seven did not document that reasonable efforts were followed. Of the remaining cases, 24 contained adequate documentation, and in 15 cases, reasonable efforts were deemed unnecessary because the child was determined to be in immediate danger, and emergency placement was granted.

CHILDREN VOLUNTARILY PLACED IN FOSTER CARE

The 1980 legislation allows Federal matching payments under title IV-E to be made for AFDC-eligible children removed from their home under a voluntary placement agreement, in lieu of previous law that permitted Federal matching only when placement resulted from a judicial determination. However, under current law a judicial determination that voluntary placement is in the best interests of the child is required within 6 months of placement and certain specifications must be included in the voluntary agreement.

To be eligible to receive funds for voluntarily placed children, States must implement the foster care protections and procedures required for their allotment of title IV-B funds in excess of $141 million (i.e., the foster care inventory, information system, case review system, and programs providing placement prevention and reunification services outlined earlier). On a yearly basis HHS is required to report to Congress on the number of title IV-E children place voluntarily, the reasons for their placement, and the extent to which such placements have contributed to the objectives of the program.

The most recent report to Congress on this subject states that in fiscal year 1988, 22 States participated in the program, the same number that participated the previous year. In 1988, a total of 50 States were eligible to participate, which was an increase of 4 States from the previous year. During fiscal year 1988, on average those voluntarily placed accounted for 1,086 children per month in foster care. From 1985 to 1988, the Federal share of claims for children placed voluntarily in foster care increased from $2.8 million (18 participating States) to $6.2 million.

According to the Department, based on placement outcome data reported by 13 of the 22 participating States in 1988, children placed voluntarily move through foster care much faster that the general foster care population, with an exit rate of 67 percent compared to 39 percent for the entire population. Some 44 percent of those placed voluntarily were eventually reunited with their families, and 31 percent were provided court ordered continuations of their placements after staying 180 days in foster care. The placement outcome for the remaining 25 percent of this population is not known. The two primary reasons for voluntary placement were child abuse and neglect (59 percent), and parental absence (13 percent), according to data supplied by 14 of the 22 participating States.

DETERMINING STATE COMPLIANCE WITH FEDERAL REVIEW REQUIREMENTS

The 1980 legislation changed the Social Security Act funding mechanisms for both the title IV-B child welfare services and the title IV-A foster care program (the latter program was transferred to the newly created title IV-E). Many of these changes involved fiscal incentives to States to use child welfare services in lieu of initial or continued foster care placement whenever possible and appropriate. Primary emphasis was placed on preventing the need for substitute care, and reunifying as many foster children as possible with their families.

REQUIREMENT FOR FEDERAL REVIEW OF STATE PRACTICES: SECTION 427 REVIEWS

As described earlier, the most direct fiscal incentive of this type is contained in section 427 of title IV-B, which specifies the child protections that must be in place in order for a State to receive its allotment of appropriated title IV-B funds in excess of $141 million. As table 17 shows, these "incentive funds" have grown in importance, rising from just 10 percent ($15.3 million) of the total amount appropriated for title IV-B in 1982, to 49 percent ($132.9 million) of the appropriation for 1991, and, if the $363.9 million the administration has proposed to be spent in 1992 is appropriated, as much as 61 percent in that year.

TABLE 17.—TITLE IV–B INCENTIVE FUNDS AVAILABLE TO STATES, FISCAL YEARS 1982–92

[Dollars in millions]

Fiscal year	Appropriation	Incentive funds	Proportion of total (percent)
1982	$156.3	$15.3	10
1983	156.3	15.3	10
1984	165.0	24.0	15
1985	200.0	59.0	30
1986	[1] 198.1	57.1	29
1987	222.5	81.5	37
1988	239.4	98.4	41
1989	246.7	105.7	43
1990	[1] 252.6	111.6	44
1991	273.9	132.9	49
1992 [2]	363.9	221.7	61

[1] The funding level for fiscal year 1986 reflects a 4.3 percent reduction in the $207 million title IV–B child welfare funds appropriated, due to the sequestration under the Gramm-Rudman-Hollings legislation. The funding level for fiscal year 1990 reflects a 1.4 percent reduction in the $256.1 million appropriated, also due to sequestration under that same legislation.

[2] Based on proposed budget for fiscal year 1992, and includes $12 million for demonstrations.

Source: Department of Health and Human Services.

REQUIRED CHILD PROTECTIONS

In 1980, following the enactment of Public Law 96–272, HHS identified a total of 18 child protections required by section 427 of title IV–B. In what came to be known as "427 reviews," the caseload of each State receiving incentive funds is examined to determine compliance with these child protections. States are not required to initiate this review process, but nearly all States have elected to undergo reviews. Two States (Alaska and Puerto Rico) have not chosen to be reviewed currently. The HHS reviews require the following:

—that the case plan for each child include a:

(1) description of the type of home or institution in which the child is to be placed;

(2) discussion of the appropriateness of the placement;

(3) plan to achieve placement in the least restrictive (most family-like) setting;

(4) plan for placement in close proximity to the parents' home, consistent with the best interest and special needs of the child;

(5) statement of how the responsible agency plans to carry out the voluntary placement agreement or judicial determination;

(6) plan for ensuring that the child will receive proper care;

(7) plan for providing services to the parents, child, and foster parents to improve conditions in the parents' home and facilitate the return of the child to the home, or into a permanent placement;

(8) plan for services to address the needs of the child while in foster care;

(9) discussion of the appropriateness of services provided;

—that the status of each child in foster care be reviewed periodically but no less frequently than once every 6 months by a court or administrative review (see protections 14 and 15) to determine the:

(10) continuing necessity for and appropriateness of placement;

(11) extent of compliance with the case plan;

(12) extent of progress made toward alleviating or "mitigating" the causes of foster placement;

(13) likely date the child may be returned home or placed for adoption or provided legal guardianship;

—that all administrative reviews must:

(14) be open to the participation of the parents;

(15) be conducted by a panel of appropriate persons, at least one of whom is not responsible for the case management of, or the delivery of services to, the child or parents;

—that procedural safeguards that pertain to parental rights are followed when:

(16) the child is removed from the parents' home;

(17) a change is made in the child's placement;

(18) any determination of the parents' visitation privileges is made.

TABLE 18.—REQUIREMENTS OF SECTIONS 427 AND 475 AND HHS'S COMPLIANCE REVIEW COMPONENTS

Requirement	Description	Review component
Inventory, sec. 427(a)(1)	Includes all children in foster care under State responsibility for 6 months preceding the inventory. State determines appropriateness of and necessity for current foster placement. Whether a child can or should be returned to parents or be freed for adoption. Services necessary to facilitate either the return of a child or the child's placement for adoption or legal guardianship.	Administrative review.
Statewide information system, sec. 427(a)(2)(A).	Includes status, demographic characteristics, location, and placement goals of foster children in care the preceding 12 months.	Administrative review.
Service program, sec. 427(a)(2)(C).	To help children where appropriate, return to families or be placed for adoption or legal guardianship.	Administrative review.
Case plan, sec. 427(a)(2)(B).	A written document that includes:	Major requirement of case record review.
	a plan to achieve placement in the least restrictive (most family-like) setting available.	Protection 3.
	a plan for placement in close proximity to the parents home consistent with the best interest and special needs of the child (sec. 475(5)(A)).	Protection 4.
	a description of type of home or institution in which a child is to be placed.	Protection 1.
	a discussion of appropriateness of placement	Protection 2.

TABLE 18.—REQUIREMENTS OF SECTIONS 427 AND 475 AND HHS'S COMPLIANCE REVIEW COMPONENTS—Continued

Requirement	Description	Review component
	a statement of how the responsible agency plans to carry out the voluntary placement agreement or judicial determination made in accordance with sec. 472(a)(1).	Protection 5.
	a plan for ensuring that the child will receive proper care..	Protection 6.
	a plan for providing services to the parents, child, and foster parents to improve conditions in the parents home and facilitate the return of the child home or permanent placement.	Protection 7.
	a plan for services to address the needs of a child while in foster care.	Protection 8.
	a discussion of appropriateness of services provided..........	Protection 9.
	where appropriate for a child 16 or over, a description of programs and services to prepare for transition to independent living.	Not part of 427 review.
Case reviews, sec. 427(a)(2)(B).	Status of each child is reviewed periodically but not less frequently than once every 6 months by a court or administrative review to determine:	Major requirement of case record review.
	continuing necessity for and appropriateness of placement.	Protection 10.
	extent of compliance with case plan:	Protection 11.
	extent of progress made toward alleviating or "mitigating" causes of foster placement.	Protection 12.
	likely date child may be returned home or placed for adoption or provided legal guardianship.	Protection 13.
	Administrative review means:	
	open to participation of the parents	Protection 14.
	conducted by panel or appropriate persons, at least one of whom is not responsible for the case management of, or the delivery of services to, the child or parents.	Protection 15.
Dispositional hearing, sec. 427(a)(2)(B) and sec. 475(5).	To be held:	
	in family or juvenile court or other court of competent jurisdiction or by administrative body approved by the court.	Major requirement of case record review.
	no later than 18 months after the original placement (and periodically thereafter during care).	Major requirement of case record review.
	to determine future status of the child (return to parent, continue foster care for special period on permanent or long-term basis, placement for adoption).	Major requirement of case record review.
	to determine transition services needed for a child 16 or older (added effective October 1, 1988).	Effective Oct. 1, 1988.
Procedural safeguards, sec. 427(a)(2)(B) and sec. 475(5).	Applied to:	
	parental rights pertaining to removal of child from parent's home.	Protection 16.
	a change in child's placement..	Protection 17.
	any determination of parents' visitation privileges..............	Protection 18.

Source: GAO/PEMD-89-17 "Implementation and Effects of Foster Care Reforms," and HHS.

HHS REVIEW PROCEDURES

As outlined in pertinent ACYF Policy Information Questions (PIQs), and in the "Section 427 Review Handbook" published by the Department in August 1988, the 427 review process of a State's foster care system (administered by the Administration for Children, Youth, and Families (ACYF)), HHS consists of two phases: (1) the administrative review, and (2) the survey of case records. The process is initiated when a State "self-certifies" after determining that it is in compliance with the 18 protections on the basis of the State's understanding of the statute. An administrative review is then conducted to determine if all policy and procedural systems necessary to implement the child protections are in place at a Statewide level. Specifically the administrative review verifies that the State has:

—conducted an inventory of the children in foster care;
—implemented a statewide information system;
—established a service program designed to assist foster children return home, or be placed for adoption or legal guardianship;
—instituted a case review system.

If the State has fully implemented these administrative components, the review process proceeds to the case record survey stage.

Three separate case record surveys are conducted in each State (an initial, subsequent, and triennial review) by a team composed of Federal and State personnel. Each of these reviews demands a higher level of compliance, and a State must have successfully passed the preceding review before proceeding to the next one. If a State does not meet the standards established for any review, the review is conducted each succeeding year until the State passes.

The initial review is conducted for the fiscal year in which the State certifies its eligibility. If a State meets the requirements of the initial review, a subsequent review is conducted the following fiscal year. Three years after successful passage of the subsequent review, a triennial review is conducted. Every 3 years following successful passage of this highest level of compliance, it is Departmental policy to re-review State practices.

For a case to successfully pass an initial, subsequent, or triennial review, the case record must include:

—a written case plan;
—an official record documenting that periodic reviews were held at least once every 6 months by a court or by an administrative review; and that
—a dispositional hearing was held by a court or court-appointed body no later than 18 months after the placement of the child, and periodically thereafter (time period determined by State) to determine the future status of the child;

Initial reviews require evidence that 13 of the 18 child protections (listed earlier) be present in 66 percent of the case records sampled, and subsequent reviews require this in 80 percent of the cases sampled in a State. Triennial reviews require evidence of 15 of the 18 child protections in 90 percent of the cases sampled. Currently, 37 States have passed this level of review (see table 19).

TABLE 19.—STATUS OF STATE COMPLIANCE WITH SECTION 427 REVIEWS 1981–89

Compliance status	Number of States	Cumulative number
Triennial review	37	37
Subsequent review	3	40
Initial review	0	40
State certified (awaiting ACYF review)	1	41
Not in compliance	6	47
Not State certified	2	49
Decision pending	3	52

Sources: GAO/PEMD–89–17, "Foster Care, Incomplete Implementation of the Reforms and Unknown Effectiveness." Updated with information supplied by HHS.

If a State is found out of compliance, ACYF issues a disallowance against the State's allotment of incentive funds for the coming fiscal year. States may appeal the disallowance to the HHS Departmental Appeals Board (DAB) but ACYF routinely withholds from a State the amount of the disallowance until the appeals process is completed.

FEDERAL REGULATIONS IMPLEMENTING THE REVIEW REQUIREMENTS

Prior to 1980, the review of State foster care and adoption services was conducted by a program review of foster care and related child welfare services, including Child Protective Services (CPS), adoption, and general system management and administration. The composition of the review teams was the same as it is currently (Federal and State personnel) but the review focused on a number of systemwide indicators of generally accepted standards of good practice. At the conclusion of the review each State was informed of its standard of care in relation to other States. Methods for the improvement of service delivery were discussed by State and Federal personnel, and no financial penalties were attached to a State's performance. Approximately 28 States participated in these program reviews on a voluntary basis until they were discontinued in 1980.

In fiscal year 1990, the Department conducted field-tests of nearly identical reviews in five States. According to officials at ACYF, it is the Department's goal to provide a more thorough assessment of participating States' child welfare systems, and offer them any needed technical assistance.

Shortly after Public Law 96–272 was enacted in 1980, the Department wrote a set of detailed regulations for determining State qualification for title IV–B incentive funds. These regulations were published in the Federal Register on December 31, 1980 as an interim final rule. Some aspects of the regulations reflected the nature of the earlier program reviews. Generally, they were very prescriptive in nature, yet they provided States several detailed options for service delivery.

However, this set of regulations never went into effect. On March 3, 1981, HHS withdrew the interim final rule, stating that the Office of Management and Budget (OMB) had not reviewed and approved the sections containing reporting and recordkeeping requirements. The following year States were informed of the manner in which the reviews would take place in ACYF–PIQ–82–06. Primarily the Policy Information Question simply restated the pertinent sections of title IV–B. The original 1980 regulations were never reissued.

During the 1980's, legal and policy interpretations issued by ACYF and the HHS Departmental Appeals Board constituted the set of standards against which State compliance has been measured. To date HHS has issued 14 Policy Interpretation Questions (PIQs), 11 Program Instructions (PIs), two Information Memorandum (IMs), and one Departmental Policy Announcement (PA) to the States. PIQs, which are the most heavily relied upon by States seeking to clarify compliance ambiguities, cover a range of topics including the requirements of preplacement prevention services and information systems, specifications on the timing and content of dispositional hearings, and operational definitions of requirements contained in titles IV–B and IV–E.

In congressional hearings throughout the 1980s, States and public interest groups asserted that a great deal of confusion surrounded compliance issues due to the absence of clear, unambiguous regulations. For instance, the Department found a number of States out of compliance due to problems related to the specified judicial process, such as the absence of formal documentation showing that certain child protections were followed.

According to a report published in November, 1982 by the American Public Welfare Association (APWA), reviewers disallowed secondary evidence (notes made by caseworkers), requiring instead that primary evidence (a court document or letter from the administrative body fulfilling the function of a judicial body) be present in the case record. A number of States complained that they were found out of compliance on the grounds that entries in the case record on the date and outcome of a judicial hearing were not sufficient documentation, even though the administration had not told them before hand that this kind of notation was insufficient, and that primary evidence was required. According to the Department, section 427 specifications now require that such primary evidence (or legible copies of primary evidence) be placed in the case record in order for States to qualify for incentive funding.

In addition to the confusion surrounding rules, large reductions in staff (combined with the cancellation of program reviews) left HHS with a limited capacity to gain knowledge of existing child welfare practices in States, and monitor and influence the delivery of these services.

RECORD OF STATE COMPLIANCE

According to HHS, most funding disallowances (resulting from sampled cases found not in compliance during periodic reviews) occur as a result of States not holding periodic reviews and dispositional hearings within the time frame specified in the statute.

From fiscal year 1982 to fiscal year 1987, 152 section 427 reviews were conducted. Twenty-five of these resulted in a failure. These States failing reviews were assessed disallowances totaling $13.4

million. The amount of the disallowance for a State failing a review is equal to the amount of incentive funds it is eligible to receive in the year for which the review was conducted. Therefore, the amounts vary widely from State to State. For example, the amount disallowed the State of Florida was $1,832,000; Maryland, $1,297,000; Connecticut, $748,000; Arkansas, $190,000; and Alaska, $163,000.

TABLE 20.—OUTCOME OF ACYF REVIEWS OF STATES' COMPLIANCE WITH SECTION 427, AS OF SEPTEMBER 1990

State [1]	1981	1982	1983	1984	1985	1986	1987	1988	1989
Alabama	NA	NA	Pass	Pass			Pass		
Alaska	NA	NA	NA	NA	NA		Pass	Fail	NA
Arizona	Pass	Pass			Pass				
Arkansas	Pass	Fail [3]	Pass			Pass		Pass	
California	NA	NA	Pass	Pass			Pass		
Colorado	Pass	Pass			Pass			Pass	
Connecticut	Pass	Pass			Fail [4]				
Delaware	NA	Pass	Pass	Pass			Pass		
District of Columbia.	NA	NA	Fail [3]	Fail	Pass	Pass			Pass
Florida	NA	Pass	Fail	Pass					
Georgia	NA	Pass	Pass			Pass			Pending
Hawaii	NA	NA	NA	NA	NA		Pass	Pass	Pass
Idaho	NA	Pass	Pass			Pass [3]			Pass
Illinois	Pass	Pass		Fail [6]					
Indiana	NA	NA	Pass	Pass			Pass		
Iowa	Pass	Pass			Pass			Pass	
Kansas	Pass	Pass			Pass			Pass	
Kentucky	Pass	Pass			Pass			Pass	
Louisiana	NA	NA	Fail	Pass	Pass			Pass	
Maine	NA	NA	Pass	Pass			Pass		
Maryland	Pass	Fail [4]	Fail [4]						
Massachusetts	NA	NA	NA	NA	NA	NA	NA	Fail	
Michigan	Pass	Pass			Pass			Pass	
Minnesota	NA	Pass	Pass			Pass			Pass
Mississippi	NA	Pass	Pass			Pass			Pass
Missouri	Pass	Pass			Pass			Pass	
Montana	Pass	Pass			Pass			Pass	
Nebraska	NA	Pass	Pass			Pass			Pass
Nevada	NA	Pass	Pass			Pass			Pass
New Hampshire	NA	Fail [3]	Pass	Fail	NA	Pending [2]			
New Jersey	Pass	Pass			Pass			Pass	
New Mexico	NA	Pass	Pass			Pass			Pass
New York	Pass	Pass			Pass			Pass	
North Carolina	NA	Pass	Pass			Pass			Pass
North Dakota	Pass	Pass			Pass			Pass	

TABLE 20.—OUTCOME OF ACYF REVIEWS OF STATES' COMPLIANCE WITH SECTION 427, AS OF SEPTEMBER 1990—Continued

State [1]	1981	1982	1983	1984	1985	1986	1987	1988	1989
Ohio	Fail [3]	Fail	Fail [3]	Fail	Pass	Pass			Pass
Oklahoma	Pass	Pass			Pass			Pass	
Oregon	Pass	Pass			Pass			Pass	
Pennsylvania	NA	NA	Pass	Pass			Pass		
Puerto Rico	Fail	NA	NA	NA	NA	NA	NA	NA	NA
Rhode Island	Fail	Pass	Fail	Pass			Pass		
South Carolina	Pass	Pass			Pass			Pass	
South Dakota	Pass	Pass			Pass			Pass	
Tennessee	Pass	Pass			Pass			Pass	
Texas	NA	Pass	Pass			Pass			Pass
Utah	Pass	Pass			Pass			Pass	
Vermont	Fail [3]	Pass	Fail [5]	NA	NA	Pending			
Virginia	Pass	Fail [3]	Fail [3]	Pass			Pass		
Washington	Pass	Pass			Pass			Pass	
West Virginia	Pass	Pass			Fail	Fail	Pending [2]		
Wisconsin	NA	Pass	Pass			Pass			
Wyoming	Pass	Fail [3]	Fail	NA	NA	NA	NA	NA	Certified [7]

---

[1] Table is for fiscal years excluding the territories which have consolidated HDS grants. Blanks indicate that the State was not reviewed that year. However, ACYF considers a State eligible for incentive funds between reviews, as long as it certifies compliance with the law. NA means that the State did not certify compliance and apply for funds or later withdrew its certification.

[2] A case-record review was conducted, but the compliance decision has not been reached.

[3] This reflects the final decision of the HHS departmental appeals board on the State's appeal.

[4] State's appeal is pending in U.S. district court.

[5] State withdrew its appeal of ACYF's decision.

[6] Remanded by court to departmental appeals board for further action.

[7] State has recertified.

Source: GAO/PEMD-89-17, "Implementation and Effects of Foster Care Reforms," and HHS.

TRENDS IN FOSTER CARE CASELOADS

The proportion of all children in the United States who are in foster care has ranged from 3.9 per 1,000 in 1962 to 4.8 per 1,000 in 1988. Despite the apparent relative stability of these numbers over the 16-year period, there have been very substantial swings in direction within the last decade. In 1980, the proportion of children in foster care was 4.4 per 1,000. The percentage dropped to 4.0 per 1,000 in 1983, and grew to 4.2 per 1,000 in 1987. However, between 1987 and 1988, the percentage of children in foster care grew very substantially, increasing to 4.8 per 1,000 in 1988. This is the largest 1-year change in the entire 16-year period (see table 21).

The number of children in Federally assisted AFDC/title IV–E foster care has grown significantly in the years since the program was created. The number grew steadily from 1962 to 1976, then decreased slightly from 1976 to 1983. Since 1983, the number of foster children funded under title IV–E has increased steadily (see table 22). In 1972, approximately 22 percent of the total foster care population was funded under title IV–E. By 1988 this proportion increased to 41 percent (table 23).

RECENT TRENDS

More detailed information is available on these trends from a number of State data collection systems. Currently, some of the most interesting data are obtained from a joint data analysis effort of the New York State Department of Social Services and the Illinois Department of Children and Family Services. Despite their notable geographic differences, both States show similarities in recent caseload trends. In 1988, New York accounted for approximately 14 percent of the total U.S. foster care caseload. Illinois accounted for approximately 5 percent.

Recent increase in caseloads

Both States' yearly admissions and discharges from foster care were fairly equal until 1986. Midway through that year the caseload in both States increased as new admissions into foster care increased and discharges from care fell. In the time period from 1983 to 1989 this resulted in a 80 percent caseload growth in New York, and a 30 percent increase in Illinois' foster care caseload. California's caseload nearly doubled in the 5-year period 1985–1989, growing from 37,000 children in 1985 to 67,000 children in 1989. Unofficial estimates indicate that the entire U.S. caseload increased from approximately 269,000 in 1983 to 360,000 in 1989, an increase of 33 percent.

The impact of crack cocaine on the child welfare system

There is widespread speculation that a significant portion of this increase resulted from the introduction of crack cocaine into the country during the mid-1980s. The availability of crack has been linked to the abuse of children of all ages. According to a 1990 publication by the House Subcommittee on Human Resources, Ways and Means, New York City officials blame the introduction of crack for the threefold increase in that city's child abuse and neglect cases involving parental substance abuse between 1986 and 1988. However, the biggest impact that crack has had on the child welfare system is the large increases in very young infants entering the foster care system at birth as a result of prenatal drug usage, drug toxicity at birth, and abandonment at the time of birth in the hospital (boarder babies). Drug-exposed infants also often enter substitute care shortly after they are born as a result of a diagnosed failure to thrive, or parental abuse and neglect.

The 1988 National Association for Perinatal Addiction Research and Education (NAPARE) estimates that 11 percent of all pregnant women use illegal drugs. A 1990 General Accounting Office (GAO) study conducted for the Finance Committee reported that the actual number of drug-exposed infants born each year is unknown, although the study noted that the two most widely cited estimates are 100,000 and 375,000. An HHS office of the Inspector General (OIG) 1989 survey of 12 cities found that 30 to 50 percent of drug-exposed infants enter foster care. Last year, half of all New York City infant foster care admissions were boarder babies. Eighty to ninety percent of these cases involved substance abuse.

Data from New York and Illinois show how these trends are stretching State child welfare systems to their limits. From 1985 to 1988, New York foster care infant admissions (children less than 1 year old) increased by 89 percent. Illinois experienced a 58 percent increase in infant admissions during these same 3 years. In 1984, only one percent of all infants born in New York City were placed in foster care, but by 1988, this increased to nearly 28 percent of all infants. In both States nearly all infant admissions occur in the first few days following birth.

In addition, this rise in infant admissions may portend large increases in foster care caseloads in the future. Not only do younger children spend the longest length of time in foster care, but historically many children that are admitted and discharged from foster care eventually reenter care. During 1989, 15 percent of New York's admissions into foster care was comprised of children reentering care. A 1988 Illinois study by researchers Dr. Mark Testa and Dr. Robert Goerge found that nearly 40 percent of the earliest cohorts of foster children that are reunified with their parents eventually reenter substitute care.

TABLE 21.—U.S. FOSTER CARE POPULATION AND U.S. POPULATION AGES 0 TO 18, 1962–88

Year	U.S. foster care population (end of fiscal year) [1]	U.S. population ages 0–18 (calendar year) [2]	Children in foster care per 1,000 in population
1962	272,000	69,864,000	3.9
1963	276,000	71,164,000	3.9
1964	287,000	72,406,000	4.0
1965	300,000	73,520,000	4.1
1966	309,600	73,179,000	4.2
1967	316,200	73,429,000	4.3
1968	320,000	73,396,000	4.4
1969	326,000	74,000,000	4.4
1970	330,400	73,516,000	4.5
1971	319,800	73,665,000	4.3
1972	NA	72,369,000	NA
1973	NA	72,243,000	NA
1974	NA	72,070,000	NA
1975	NA	71,402,000	NA
1976	NA	70,500,000	NA
1977	[3] NA	69,699,000	NA
1978	NA	67,003,000	NA
1979	NA	68,307,000	NA
1980	[4] 302,000	67,913,000	4.4
1981	[4] 274,000	67,571,000	4.1
1982	[4] 276,000	67,118,000	4.1
1983	[5] 269,200	66,768,000	4.0
1984	[5] 275,800	66,863,000	4.1
1985	[5] 276,300	66,797,000	4.1
1986	[6] 273,500	66,932,000	4.1
1987	[6] 285,000	67,221,000	4.2
1988	[6] 323,000	67,709,000	4.8

[1] Data from Child Welfare Research Notes #8 (July 1984), published by Administration for Children, Youth, and Families, HDS, HHS. This note cites as sources of data for the foster care population: annual reports from 1962–72 of the Children's Bureau and the National Center for Social Statistics, Social and Rehabilitation Services; National Study of Social Services to Children and their Families, published by ACYF in 1978, for 1977 data; and the Office of Civil Rights, HHS, report, "1980 Children and Youth Referral Survey: Public Welfare and Social Service Agencies" for 1980 data.

[2] U.S. Census Bureau, Population Division, unpublished data (1962–1980); U.S. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States 1985, 1990.

[3] One study involving a sample survey of 9,600 cases was used to project a national foster care caseload in 1977 of 502,000. This is so far out of line with data for other years as to appear highly questionable.

[4] Data were collected using a variety of methodologies and may not be comparable with each other or with other years.

[5] "State Child Welfare Abstracts 1980–1985," Maximus Inc. prepared for Office of Social Services Policy, Assistant Secretary for Planning and Evaluation, HHS, December 1987.

[6] Unpublished VCIS data supplied by the American Public Welfare Association.

TABLE 22.—REPORTED AFDC/IV–E FOSTER CARE POPULATION AND TOTAL AFDC CHILDREN, FISCAL YEARS 1962–91

Fiscal year	States reporting	Children receiving AFDC/IV–E foster care (average monthly) [1]	Children receiving AFDC (average monthly) [2]	Proportion (percent)
1962	11	989	2,781,000	NA
1963	14	2,308	[3] 2,921,000	.1
1964	21	4,081	3,075,000	.1
1965	23	5,623	3,243,000	.2
1966	23	7,385	3,369,000	.2
1967	25	8,030	3,558,000	.2
1968	27	8,500	4,013,000	.2
1969	30	16,750	4,591,000	.4
1970	41	34,450	5,494,000	.6
1971	45	57,075	6,963,000	.8
1972	48	71,118	7,698,000	.9
1973	NA	84,097	7,965,000	1.1
1974	NA	90,000	7,824,000	1.2
1975	[4] 50	106,869	7,928,000	1.3
1976	same	114,962	8,156,000	1.4
1977	same	110,494	7,818,000	1.4
1978	same	106,504	7,475,000	1.4
1979	same	103,771	7,193,000	1.4
1980	same	100,272	7,320,000	1.4
1981	same	104,851	7,615,000	1.4
1982	same	97,309	6,975,000	1.4
1983	same	93,360	7,051,000	1.3
1984	same	102,051	7,153,000	1.4
1985	same	109,122	7,165,000	1.5
1986	same	110,749	7,294,000	1.5
1987	same	118,549	7,381,000	1.6
1988	same	132,757	7,326,000	1.8
1989	same	156,658	7,370,000	2.1
1990	same	[3] 173,152	7,744,000	2.2
1991	same	[3] 197,393	NA	NA

[1] Incomplete data based on voluntary reporting prior to 1975.

[2] Includes foster care children 1971–1981.

[3] Estimate.

[4] Plus the Virgin Islands, Puerto Rico, Guam, and D.C.

Sources: Senate Finance Committee Hearings on Public Assistance Act of 1962 and Public Assistance Statistics (for selected years), Department of Health, Education, and Welfare; Division of Research, Evaluation, and Statistics, Office of Family Assistance, Social Security Administration; Office of Family Assistance and Office of Financial Management, Family Support Administration, HHS.

TABLE 23.—AFDC/IV-E FOSTER CARE AND TOTAL FOSTER CARE POPULATION IN THE UNITED STATES (FISCAL YEARS 1962-91)

Fiscal year	AFDC/IV-E foster care children (average monthly number)	Total United States in foster care	Proportion (percent)
1962	989	272,000	0.4
1963	2,308	276,000	0.8
1964	4,081	287,000	1.4
1965	5,623	300,000	1.9
1966	7,385	309,400	2.4
1967	8,030	309,600	2.6
1968	8,500	316,200	2.7
1969	16,750	320,000	5.2
1970	34,450	326,000	10.6
1971	57,075	330,400	17.3
1972	71,118	319,800	22.2
1973	84,097	NA	NA
1974	90,000	NA	NA
1975	106,869	NA	NA
1976	114,962	NA	NA
1977	110,494	[1] NA	NA
1978	106,504	NA	NA
1979	103,771	NA	NA
1980	100,272	[2] 302,000	33.2
1981	104,851	[2] 274,000	38.3
1982	97,309	[2] 276,000	35.3
1983	93,360	[3] 269,000	34.7
1984	102,051	[3] 276,000	37.0
1985	109,122	[3] 276,000	39.5
1986	110,749	[4] 273,500	40.5
1987	118,549	[4] 285,000	42.0
1988	132,757	323,000	41.1
1989	156,658	NA	NA
1990 (estimate)	173,152	NA	NA
1991 (estimate)	197,393	NA	NA

[1] See footnote 3, table 21.
[2] See footnote 4, table 21.
[3] See footnote 5, table 21.
[4] See footnote 6, table 21.

Sources: See tables 21 and 22.

SOURCES OF NATIONAL DATA ON FOSTER CHILDREN; DATA LIMITATIONS

The primary source of national data on foster care is the Voluntary Cooperative Information System (VCIS) conducted by the American Public Welfare Association (APWA). This voluntary survey was begun by APWA, with support from the U.S. Department of Health and Human Services (HHS), in 1982. VCIS reports are available covering foster care activities in fiscal year 1982 through fiscal year 1987. The most recent data, covering fiscal year

1987, were published in January 1991.[11] In addition, some preliminary data are available from the VCIS on the numbers of children in care through fiscal year 1989.

For fiscal year 1987, 46 States, the District of Columbia and Puerto Rico responded to the voluntary survey. However, not all States and jurisdictions were able to respond to every question in the survey; therefore, the data are incomplete for many items, and, according to APWA, should be considered "rough" national estimates. It also should be noted that definitions of some terms varied among States and that reporting periods were not identical among States. Although all data are reported as applicable to fiscal year 1987, States were able to use either the Federal fiscal year or their own annual reporting period or fiscal year, which fell between July 1986 and December 1987.

The VCIS data report on all children in substitute care under the management and responsibility of the State child welfare agency, including: foster family care (relative and nonrelative), group homes, child care facilities, emergency shelter care, supervised independent living, nonfinalized adoptive placements, and any other arrangement considered 24-hour substitute care by the State agency. No distinctions are made among these different forms of substitute care. Finalized adoptions are not included in the VCIS data; however, nonfinalized adoptions are reflected in the data.

Federal legislation in 1986 set in motion a process that eventually should result in a mandatory Federal data collection system for foster care and adoption assistance. Once operational, the new data collection system will replace the VCIS. Development of this data collection system is discussed later in this section.

The VCIS data provide the most complete, albeit limited, picture of foster care children and their circumstances. At least two other studies are useful in identifying major trends and in supplementing the VCIS findings. The House Select Committee on Children, Youth and Families conducted a survey in 1989 of foster care in the 10 most populous States, the results of which were published in a report which also summarized the findings of congressional hearings and other studies.[12] The Select Committee data should be used with caution because not all 10 States were able to respond to all data elements, and definitions and reporting periods varied as in the VCIS data. However, the Select Committee's report is useful as one of the few sources of recent data estimates on the number of children in care.

In addition, the National Black Child Development Institute (NBCDI) reported in 1989 on the results of a 2½-year study of black children in foster care in five major cities (Detroit, Houston, Miami, New York, and Seattle).[13] This study attempted to develop more detailed information than obtained through the VCIS system, such as information on children's education and health status, characteristics of their biological families, and specific reasons for placement. Readers should keep in mind that the NBCDI study focused only on black children, and took place only in five cities. Further, NBCDI identified several methodological limitations in its study. Data were collected primarily by volunteers and thus were subject to varying interpretations. Reporting periods varied among cities, and the definition of foster care used in the NBCDI survey, as in the VCIS and Select Committee reports, was the broadest possible and included all forms of 24-hour substitute care. Nonetheless, the NBCDI report is useful in supplementing other data and in drawing a general picture of the circumstances of a significant portion of the children in foster care.

---

[11] Characteristics of Children in Substitute and Adoptive care, based on fiscal year 1987 data. American Public Welfare Association, Washington, DC, January 1991.

[12] U.S. Congress. House. Select Committee on Children, Youth and Families. No Place to Call Home: Discarded Children in America. Committee Print, 101st Cong., 1st Sess. Washington, U.S. Govt. Print. Off., 1989.

[13] Who Will Care When Parents Can't? A Study of Black Children in Foster Care. National Black Child Development Institute, Washington, DC, 1989.

Where possible and useful, this section will contrast the most recent VCIS data with comparable data gathered through the VCIS in earlier years. However, for most data elements measured through the VCIS, the middle 1980s were a relatively stable period for foster care. This section does not discuss the more significant changes that took place in substitute care for children from the 1970s to the 1980s. Similarly, because very little detailed national information is available about foster care since 1987, some of the very recent trends, which have been suggested through anecdotal and individual State reports, may not be reflected in the national data discussed here.

NUMBER OF CHILDREN IN SUBSTITUTE CARE

No precise figure is currently available on the number of children in foster (or substitute) care at a given point in time. However, there are various estimates of the number of children in substitute care. As mentioned above, readers should keep in mind that not all children described as being in substitute care are living in foster family homes, but may be in other forms of substitute care such as group homes or residential institutions, emergency shelters, or, if older teens, living alone with supervision.

The latest VCIS report provides several estimates of the number of children in substitute care in fiscal year 1987 (defined as the Federal fiscal year or the State's fiscal year). At the beginning of fiscal year 1987, APWA reports that an estimated 280,000 children were in substitute care, and at the end of the fiscal year, roughly 300,000 children were in substitute care.

In addition to the number of children reported as being in care on the first and last days of the fiscal year, the numbers of children who entered and left care during the year and a cumulative total number of children served throughout the year also were estimated by APWA, as shown below. As with all VCIS data, these numbers should be read carefully because not all States responded to all data questions; national figures are estimates based on State reports.

TABLE 24.—CHILDREN IN SUBSTITUTE CARE, FISCAL YEAR 1987

Point in time	Number of children
In care, start of fiscal year 1987	280,000
Entered during fiscal year 1987	[1] 222,000
Total served during fiscal year 1987	502,000
Left during fiscal year 1987	202,000
In care, end of fiscal year 1987	300,000

[1] According to reports from 18 States, 90 percent of children who entered care in fiscal year 1987 were new entrants; 10 percent were re-entrants.

Source: APWA, January 1991.

The following table shows the number of children in care at the start and end of the fiscal year, as reported by APWA since the beginning of the VCIS survey in 1982. These numbers are not absolutely comparable from year to year because of some differences in definitions; they should be viewed as trend data and not as precise counts of the number of children in care.

TABLE 25.—CHILDREN IN SUBSTITUTE CARE, FISCAL YEARS 1982–87

Fiscal year	Number of children, start of year	Number of children, end of year
1982	273,000	262,000
1983	263,000	269,000
1984	272,000	276,000
1985	270,000	276,000
1986	273,000	280,000
1987	280,000	300,000

Source: APWA, January 1991.

The following table demonstrates the dynamics of the substitute care population for fiscal year 1982 through 1987.

TABLE 26.—MOVEMENTS OF SUBSTITUTE CARE CHILDREN IN FISCAL YEARS 1982–87

Year	Entered care	Incidence rate [1]	Total served	Left care
1982	161,000	2.5	434,000	172,000
1983	184,000	2.5	447,000	178,000
1984	184,000	2.4	456,000	180,000
1985	190,000	2.5	460,000	184,000
1986	183,000	2.4	456,000	176,000
1987	222,000	2.9	502,000	202,000

[1] Number of children in every 1,000 children 20 years of age and under in the country who entered substitute care.

Source: APWA, January 1991.

Although the most recent complete results of the VCIS are for fiscal year 1987, VCIS data are also available for the number of children in substitute care at the end of fiscal years 1988 and 1989, and are shown in table 27. These figures were developed during research conducted by APWA on the impact of substance abuse on the child welfare system.[14] While the 1988 figure is based on reports from 50 States and the District of Columbia, the 1989 figure is based on reports from 9 States with the largest number of substitute care children. APWA characterizes the 1989 figure as "tentative" but likely to be conservative.

TABLE 27.—CHILDREN IN SUBSTITUTE CARE, FISCAL YEARS 1988–89 (APWA)

Fiscal year	Number of children, end of fiscal year
1988	330,000
1989	[1] 360,000

[1] This figure is extrapolated from reports from nine States; "tentative yet conservative," according to APWA.
Source: APWA, February 1990.

The following table shows the number of children in substitute care, by State, based on VCIS data collected by APWA.

TABLE 28.—STATE SUBSTITUTE CARE POPULATIONS FOR FISCAL YEARS 1986, 1987, 1988, AND 1989 BASED ON VCIS DATA

State	Fiscal year—			
	1986	1987	1988	1989
Alabama	4,337	4,390	4,417	
Alaska	1,232			
Arizona	2,434	2,641	3,008	
Arkansas	1,321	1,032	1,077	
California [1]	47,327	51,821	62,514	66,763
Colorado	3,100			
Connecticut	3,530	3,370	3,631	
Delaware	763	696	698	
District of Columbia		2,120	2,210	
Florida [1]	6,802	7,017	7,725	7,544
Georgia [1]	9,311	10,356	11,597	13,325
Guam		37	39	
Hawaii	1,267	1,423	1,400	
Idaho	756	1,307	770	
Illinois [1]	14,472	15,829	17,425	19,296

---

[14] Children of Substance Abusing/Alcoholic Parents Referred to the Child Welfare System: Summaries of Key Statistical Data Obtained from States. American Public Welfare Association, Feb. 1990.

TABLE 28.—STATE SUBSTITUTE CARE POPULATIONS FOR FISCAL YEARS 1986, 1987, 1988, AND 1989 BASED ON VCIS DATA—Continued

State	Fiscal year—			
	1986	1987	1988	1989
Indiana	4,730	5,207	6,043	
Iowa	3,579	3,856	4,012	
Kansas	4,203	4,277	4,443	
Kentucky	2,863	3,235	3,232	
Louisiana	6,717	6,717	6,097	
Maine	1,855	1,885	1,815	
Maryland	5,198	5,470	5,868	
Massachusetts [1]	7,546	8,814	9,588	10,284
Michigan [1]	8,566	9,791	11,302	
Minnesota	5,616	5,924	5,900	
Mississippi	2,219	2,587	2,702	
Missouri	6,354	6,515	6,902	
Montana				
Nebraska	2,438	2,432	2,296	
Nevada	1,876	1,264	1,590	
New Hampshire		1,264	1,445	
New Jersey [1]	6,597	8,681	8,542	8,798
New Mexico	2,062	2,088	2,195	
New York [1]	27,504	29,197	45,746	52,189
North Carolina	6,254	6,124	6,126	
North Dakota	587	540	589	
Ohio [1]	11,966	11,263	12,539	14,200
Oklahoma	2,075	2,048	2,217	
Oregon	3,250	3,623	3,885	
Pennsylvania [1]	14,685	13,433	14,636	15,416
Puerto Rico	2,252			
Rhode Island	2,085	2,293	2,569	
South Carolina	3,692	3,563	3,583	
South Dakota	547	461	446	
Tennessee	4,409	4,590	5,077	
Texas	4,727	4,769	5,449	
Utah	1,132	1,176	1,118	
Vermont	1,025	987	1,025	
Virginia	5,902	5,898	6,011	
Virgin Islands				
Washington	5,789	5,632	5,725	
West Virginia		1,955		

TABLE 28.—STATE SUBSTITUTE CARE POPULATIONS FOR FISCAL YEARS 1986, 1987, 1988, AND 1989 BASED ON VCIS DATA—Continued

State	Fiscal year—			
	1986	1987	1988	1989
Wisconsin	4,833	4,326	5,018	....
Wyoming	595	608	762	....

[1] These 10 States had the largest substitute care populations at the end of fiscal year 1988, according to these VCIS data.

Source: "Children of Substance Abusing/Alcoholic Parents Referred to the Public Child Welfare System: Summaries of Key Statistical Data Obtained From States," a report prepared under contract awarded to the American Enterprise Institute, February 1990.

In addition to the above estimates for recent years, the House Select Committee on Children, Youth and Families surveyed the 10 most populous States on their foster care programs in fiscal years 1986, 1987 and 1988. On the basis of this 10-State survey, plus information from one additional State, the Select Committee estimated the following numbers of children in substitute care, at any given point during the year, nationwide:

TABLE 29.—CHILDREN IN SUBSTITUTE CARE, FISCAL YEARS 1986–88 (SELECT COMMITTEE)

Fiscal year	Number of children, average throughout year
1986	289,000
1987	307,750
1988	340,300

Source: House Select Committee on Children, Youth and Families, November 1989.

One additional set of figures is available relating to the number of children in foster care. Federal reimbursement to States for maintenance costs associated with foster children whose biological families qualify for Aid to Families with Dependent Children (AFDC) is available under Title IV–E of the Social Security Act. The average monthly number of children for whom Federal reimbursement is claimed has increased from 97,309 in 1982 to an estimated 156,658 in 1989. HHS estimates that, in fiscal year 1991, reimbursement will be claimed for an average monthly caseload of 197,393.[15]

It is generally considered that the number of children for whom Title IV–E reimbursement is claimed represents approximately 40 percent of the entire foster care caseload.[16] Thus, based on the HHS estimate of the number of federally subsidized children in care in 1989, it could be calculated that approximately 390,000 children were in care overall in that year. This figure is not inconsistent with APWA's tentative estimate of 360,000 children in fiscal year 1989.

---

[15] See table 22.

[16] American Public Welfare Association, W-Memo. Aug. 1, 1989, p. 13.

Some caution should be used in assessing these data. The extent to which States identify IV-E eligible children is uneven. However, a number of States are believed to have been making increased efforts to do so in order to claim Federal matching. Some of the increased IV-E caseload, therefore, could represent a shift of categories rather than an absolute increase.

CHARACTERISTICS OF CHILDREN IN SUBSTITUTE CARE

Much of the demographic data collected on children in substitute care through the VCIS reflect three different groupings: children entering care during the study period, all children remaining in care at the end of the period, and children who left care during the period. The following sections will summarize these data. Again, readers should keep in mind that different numbers of States provided information for each data element; therefore, comparisons should be made cautiously.

Age.—The following table shows the age breakdown of children entering care, in care, and leaving care during fiscal year 1987. APWA's analysis of these data with comparable information from previous years shows gradual increases in the percentages of younger children entering foster care from fiscal year 1983 through fiscal year 1987. Moreover, while the percentage of children under age 1 in substitute care is small (4.2 percent), the proportion of children in this age group who entered care (12.1 percent) is two and a half times the percentage of children under age 1 who left care (4.8 percent).

TABLE 30.—AGES OF CHILDREN ENTERING, IN, AND LEAVING SUBSTITUTE CARE, FISCAL YEAR 1987

[In percent]

Age range	Entering	In care	Leaving
All ages	100	100	100
Under 1 year	12.1	4.2	4.8
1 to 5 years	25.4	25.2	23.5
6 to 12 years	26.9	30.3	23.9
13 to 18 years	34.0	37.3	42.5
19 years and older	.5	2.8	4.5
Age unknown	.1	.2	.8
Median age (years)	8.6	10.1	11.4
Number of States reporting	24	26	24

Source: APWA, January 1991.

The House Select Committee on Children, Youth and Families also examined the ages of children in its 10-State survey, and estimated that 42 percent of children in substitute care nationwide were under age 6 in 1988, compared with 37 percent in 1985. Of the 1,003 black children included in the National Black Child Development Institute 5-city survey, 49 percent were under age 6 in 1986, 20 percent were between the ages of 6 and 9, 27 percent were 10 to 15 years old, and 6 percent were ages 16 through 18, according to the NBCDI report.

Gender.—Children of both genders are placed at roughly equal rates. The VCIS data report that 51.1 percent of children in substitute care in fiscal year 1987 were male; 48.8 percent were female. A comparison of this finding with data from previous years found no significant change since the study was begun in fiscal year 1982.

Race/Ethnicity.—Although half the children in foster care are white, black children are overrepresented in the foster care population. The following table indicates the racial composition of children who entered substitute care during fiscal year 1987, who were in care at the end of fiscal year 1987, and who left substitute care during fiscal year 1987. APWA's comparison of these data with comparable information from previous years indicates a decrease in the percentage of white children in foster care since fiscal year 1983 and an increase in the percentages of black children.

TABLE 31.—RACE/ETHNICITY OF CHILDREN ENTERING, IN, AND LEAVING CARE, FISCAL YEAR 1987

[In percent]

Race/ethnicity	Entering	In care	Leaving
White	49.9	46.1	55.4
Black	30.7	37.1	26.5
Hispanic	10.8	10.2	9.7
Other	4.7	4.4	5.2
Unknown	3.9	2.2	3.2
Number of States reporting	24	31	26

Source: APWA, January 1991.

The House Select Committee on Children, Youth and Families also looked at the issue of racial composition in its survey and estimated, based on its survey, that the share of minority children in foster care had increased from 41 percent in fiscal year 1985 to 46 percent in 1988.

Disability/Health Status.—Based on reports from 23 States, APWA found that 20 percent of children in substitute care at the end of fiscal year 1987 had one or more disabling conditions. This finding has been approximately the same since fiscal year 1982, according to the VCIS results.

The National Black Child Development Institute did not specifically address the issue of disability but did determine that 75 percent of the black children in its 5-city study were reported as "healthy" or "having no health problems." The NBCDI also attempted to gather information on the children's mental health but determined that for 80 percent of the children under age 6, mental health assessments were either not conducted or were not included in the child's record. Mental health assessments were conducted and included in the records for 41 percent of the 6- to 12-year-olds, and for 56 percent of the children between 13 and 18 years of age. The NBCDI did not report the results of these assessments, however.

School assessments of children in the NBCDI study, to the extent that they were available, indicated that 7 percent of the total population (including children not yet of school age) were found to have an educational disability and 1 percent were mentally retarded. Of the total population of foster children included in the study, school assessments were not applicable for 41 percent (this group included children not yet of school age), and were not included in the child's record for another 16 percent of the total. Of the remainder of children, 20 percent were assessed by schools as average, 3 percent were assessed as above average, and 12 percent were considered below average.

Family Characteristics.—The NBCDI study attempted to gather information on the characteristics of biological families of the children who were placed in foster care. These data must be read cautiously because they are based on a small sample and information on each factor was not necessarily included in all records examined by NBCDI. Thus, while these data cannot necessarily be used to generalize about the families of all black children in foster care, the information is nonetheless interesting and is among the only recent national information on biological families of foster children.

The NBCDI study found that mothers of black foster children in the five-city survey were, on average, 23 years old when their children were born and 29 years old when their children were placed in substitute care. Fathers of foster children had an average age of 28 when their children were born and an average age of 34 when their children were placed in care.

Information on the educational level of mothers of foster children was not available in 45 percent of cases. Of those for whom information was available, about 47 percent of mothers had attended some high school, and another 31 percent had high school or equivalency diplomas. About 10 percent of mothers had gone through 8th grade or less, and another 10 percent had attended some college or technical school. College graduates comprised 2 percent of the mothers.

A large number of parents or primary caregivers were reported as having health problems, according to the NBCDI research. Information was not available for 15 percent of the parents or primary caregivers. Moderate or major health problems were reported for 48 percent of parents or primary caregivers, another 6 percent had minor health problems, and 46 percent were reported as healthy. Of particular significance was the type of health problem or illness experienced by parents. Among primary caregivers with a health problem, substance abuse was reported as the problem in 78 percent of cases. Again, it should be remembered that this finding is based on a small sample in five cities.

Almost half—46 percent—of black foster children in the NBCDI study came from single-parent families. Another 12 percent came from families with both parents present. About 9 percent of children came from extended families with a parent present and other relatives, and an equal number lived in extended families with relatives but without a parent present. Ten percent of children came from "augmented" families with a parent present and other adults who were not relatives, and 2 percent were from augmented families with no parent present. About 5 percent of children were from blended or stepfamilies, and 6 percent of children in the NBCDI study group had been living in hospitals before placement in foster care.

Mothers were the head of household for 62 percent of the study children before they had been placed in foster care. In 13 percent of cases, fathers were the head of household, and grandparents were household heads in another 10 percent of cases. For the remainder, the head of household was another relative, a family friend, or a stepparent.

The majority of foster children in the NBCDI study came from households receiving public assistance. AFDC was the primary source of income for 65 percent of the cases, and earnings were the primary source of income for 28 percent. Another 6 percent of households received their primary income from Social Security or Supplemental Security Income.

Finally, the NBCDI collected information on the average number of siblings of children in foster care. The children in the study group in the 5 cities had an average of 2.2 siblings, although these brothers and sisters did not necessarily live with the child or family at the time of placement.

REASONS FOR PLACEMENT IN SUBSTITUTE CARE

For fiscal year 1987, the VCIS data report reasons children were placed in substitute care in 19 States. The majority of children—70.8 percent—were placed in substitute care either for their protection or because their parent was unable or unavailable to care for them. However, since fiscal year 1984 there has been some decrease in the percentage of children placed in care as a protective service (55.7 percent in fiscal year 1984) and an increase in parent condition or absence as a reason for placement (17.0 percent in fiscal year 1984).

TABLE 32.—REASONS CHILDREN ENTERED SUBSTITUTE CARE, FISCAL YEAR 1987

	Percent
Protective service	49.8
Parent condition or absence	21.0
Status offense/delinquent	12.8
Relinquishment of parental rights	1.5
Handicap of child	2.1
Other [1]	8.8
Unknown	4.0

---

[1] As described by APWA, "other" includes a parent-child relationship problem, family interaction problem, a plan for adoption, subsidized adoption, deinstitutionalization, training/education, and unwed motherhood.

Source: APWA, January 1991.

The National Black Child Development Institute categorized reasons for placement differently in its study, but its overall finding was similar to that of APWA; the majority of children were placed in out-of-home care primarily for their own protection. Neglect was the cause in 41 percent of cases, and abuse was the cause in 26 percent of the cases. Another 8 percent of children had been abandoned, and "inability of parent" was cited in 5 percent of cases. In 17 percent of the cases, children were placed through a voluntary agreement between the parents and the placement agency.

The NBCDI attempted to obtain more detailed reasons for children entering substitute care. Parent-related or environmental reasons were reported in almost all cases studied by NBCDI, although these were not necessarily the primary cause of placement. Multiple causes were often reported for each case; therefore, the following percentages total to more than 100 percent.

The most frequently reported parent-related factor was drug abuse in the family, reported in 36 percent of cases, followed by alcoholism, reported in 20 percent of cases. These figures cannot necessarily be added to achieve a total for substance abuse, since drug abuse and alcoholism may both have been reported for the same case. Other parental factors included mental illness (reported in 14 percent of cases) and incarceration (reported in 11 percent of cases).

Environmental factors included inadequate housing (reported in 30 percent of cases), and homelessness or living in a shelter (reported in 11 percent). Again, these numbers should not be added because both factors may have been reported for the same case. Poverty was reported as an environmental factor contributing to a child's placement in 25 percent of the cases.

Child-related factors contributing to foster care placement were reported in roughly a third of the cases looked at by NBCDI in the five cities. Again, it should be remembered that these factors, like the parental and environmental factors described above, were not necessarily the primary cause for placement, but more likely were one of several factors resulting in the child's removal from home. When child-related causes were reported, the most frequently reported factor was emotional or behavioral problems of the child, cited in 62 percent of cases. The next most common factor was the child running away, reported in 24 percent of cases. In 12 percent of cases with child-related factors as categorized by NBCDI, the children were boarder babies in hospitals. Antisocial behavior on the part of the child was cited in 11 percent of cases with reported child-related factors.

LEGAL STATUS AND PERMANENCY GOALS

The VCIS data for 22 States in fiscal year 1987 report that parental rights had either been terminated or relinquished for 10.4 percent of children in substitute care during that year. Most of the children in this category were reported by States as legally free and available for adoption. For the remainder of children in care, parental rights had not been terminated or relinquished in most cases.

The following table indicates the permanency planning goals for substitute care children in fiscal year 1987, according to reports from 20 States. As the table shows, family reunification was the permanency goal for slightly more than half the children in care.

TABLE 33.—PERMANENCY PLANNING GOALS FOR CHILDREN IN CARE, FISCAL YEAR 1987

	Percent
Family reunification	53.7
Long-term foster care	15.9
Adoption	15.1
Independent living	7.2
Guardianship	3.6
Care and protection in substitute care	1.3
Unknown	3.2

Source: APWA, January 1991.

Comparing the data in table 33 with earlier years shows a significant increase in family reunification as a permanency goal. Family reunification was the goal for 46.6 percent of children in fiscal year 1983, according to VCIS data, compared with 53.7 percent of substitute care children in fiscal year 1987, as indicated in the above table.

The NBCDI study also looked at permanency plans for black children in its study group and found that reunification with parents (usually the mother) was the most prevalent permanency goal (42 percent of the children in substitute care), followed by other relative placement (17 percent). Adoption was the permanency goal for another 17 percent of children in care in the NBCDI study; long-term foster care was the goal for 8 percent; and independent living was the permanency goal for 9 percent of children.

For those children still in care for whom family reunification was a goal, the NBCDI study attempted to determine what barriers to reunification existed. Multiple barriers were identified; therefore, the following percentages total to over 100 percent because more than one barrier was identified in many cases. The leading reported barrier to reunification was lack of cooperation from the parent (46 percent), followed by inadequate housing (34 percent). Drug addiction of the parent was identified in 30 percent of cases, and a lack of parenting skills was identified in 26 percent of cases. Lack of finances was cited in 22 percent of cases, and parents' whereabouts were unknown in 20 percent. Mental instability of parents was reported in 15 percent of cases; legal barriers were cited in 11 percent; and alcoholism of parents was reported in 10 percent of cases.

LIVING ARRANGEMENTS OF CHILDREN IN SUBSTITUTE CARE

The VCIS data for fiscal year 1987 contain information on the living arrangements of substitute care children in 31 States. The following table shows that the majority of substitute care children were living in foster family homes, although a significant percentage were living in either group homes, residential treatment centers, or emergency shelters. There does not appear to be dramatic changes in these categories compared with earlier years.

TABLE 34.—LIVING ARRANGEMENTS OF CHILDREN IN CARE, FISCAL YEAR 1987

	Percent
Foster family homes	70.6
Group homes/residential treatment/emergency shelters	19.3
Non-finalized adoptions	3.2
Independent living	1.1
Other	5.2
Unknown	.6

Source: APWA, January 1991.

While the NBCDI study did not collect data on the living arrangements of black children in substitute care, the issue of relative caretakers was explored. Relatives were considered as possible placements for children in 73 percent of cases reviewed by NBCDI in the 5 cities. Of those relatives considered as resources, 57 percent actually provided some assistance, and of these, 68 percent provided foster homes for related children.

When viewed as a percentage of all substitute care children in the NBCDI study, relatives served as foster parents for somewhat less than 30 percent of children. In 13 percent of cases where relatives provided assistance, they served as legal guardians but not necessarily as foster parents. Relatives most commonly providing assistance to substitute care children were grandparents, who accounted for 53 percent of the relatives providing aid.

NUMBER AND DURATION OF PLACEMENTS WHILE IN FOSTER CARE

The VCIS collected data on the number of placements experienced by children in care at the end of fiscal year 1987, during the preceding 3 years. As the table below shows, more than half the children in care at the end of fiscal year 1987 had experienced more than one placement, according to data from 18 States.

TABLE 35.—NUMBER OF PLACEMENTS DURING PREVIOUS THREE YEARS, FOR CHILDREN IN CARE AT END OF FISCAL YEAR 1987 [1]

	Percent
1 placement	48.8
2 placements	23.7
3 to 5 placements	20.1
6 or more placements	6.9
Unknown	.5

[1] Includes current placement.

Source: APWA, January 1991.

A comparison of these data with previous years, while not strictly comparable due to differences in the number of States reporting, suggests a trend toward more multiple placements between fiscal year 1982 and fiscal year 1987. Specifically, a total of 43.1 percent of children in care at the end of fiscal year 1982 had been in more than one placement, compared with 50.7 percent at the end of fiscal year 1987.

The NBCDI study calculated the average number of placements experienced by black children in its study group, including both children still in care at the end of the study period and children who had been discharged from substitute care during the study period. The average number of placements reported by NBCDI was 2.2 per child. However, in two of the study cities—Miami and Seattle—children are usually placed in a temporary setting before being transferred to a more permanent foster home, potentially inflating the average number of placements reported.

Information on the amount of continuous time spent in substitute care was collected through the VCIS for two groups of children: those who had left substitute care during fiscal year 1987, and those who remained in substitute care at the end of fiscal year 1987. The following table indicates the length of time in continuous care experienced by these two groups.

TABLE 36.—LENGTH OF TIME IN CONTINUOUS CARE, FISCAL YEAR 1987

[In percent]

	Children leaving care	Children in care
0 to 6 months	42.8	24.3
6 to 12 months	15.1	17.6
1 to 2 years	17.1	21.4
2 to 3 years	8.7	11.8
3 to 5 years	8.6	11.7
5 years or more	6.5	12.1
Unknown	1.2	1.1
Median (months)	9.1	15
Number of States	22	23

Source: APWA, January 1991.

As the table indicates, children leaving care during fiscal year 1987 were more likely to have been in care 1 year or less (57.9 percent), while children remaining in care at the end of the year were more likely to have been in care 1 year or more (57 percent).

Data on length of stay for children leaving care during the fiscal year were not collected prior to fiscal year 1985, so a comparison of this factor with earlier years is not available. However, a comparison with fiscal year 1982 data on length of stay for children remaining in care at the end of the year indicates that the percentage of children in care for 5 or more years has decreased from 18.2 percent to 12.1 percent, and the percentage of children in care 6 months or less has increased from 21.7 percent to 24.3 percent. Fiscal year 1982 data were reported for 26 States.

The NBCDI study also examined the length of time black children spent in substitute care and found that children in its study group spent an average of 13 months in care, although this average fluctuated widely from 7 months in Houston to 26 months in Miami. This variation may be due to the manner in which the information was collected. The NBCDI study also explored the issue of caseworker turnover, and found that children in its study group had an average of 2.5 caseworkers during their tenure in foster care.

OUTCOMES FOR CHILDREN LEAVING CARE

Data are available from the VCIS from 23 States on the outcomes for children who left care during fiscal year 1987. The following table indicates that the majority of children were reunified with their families.

TABLE 37.—OUTCOMES FOR CHILDREN WHO LEFT CARE, FISCAL YEAR 1987

	Percent
Reunified	62.5
Adopted	8.5
Reached age of majority/emancipated	9.9
Other [1]	13.4
Unknown	5.7

[1] "Other" includes such reasons as running away, marriage, incarceration, death, discharge to another agency, or legal guardianship established.

Source: APWA, January 1991.

A comparison of these data with earlier years indicates that family reunification significantly increased from 49.7 percent in fiscal year 1982 to 62.5 percent in fiscal year 1987.

When evaluating these data on outcomes for children leaving care, it should be remembered that a portion of these children will likely return to substitute care at some point. As noted earlier, 10 percent of children entering care in fiscal year 1987 were reentrants, according to reports from 18 States.

Of those black children in the NBCDI study who were discharged during the study period, 55 percent were reunified with their families and another 23 percent were placed with relatives. Legal guardianship was established for 8 percent of the children, and 7 percent were adopted. Independent living for older children was established for 4 percent, and in 2 percent of cases, children left without authorization.

TRENDS IN CHILD WELFARE COSTS

Given the trends in foster care caseloads and the Federal requirements of Public Law 96-272, it is not surprising that funding for the title IV-E foster care program has increased significantly from 1981 to 1991. Based on administration estimates for fiscal year 1991, Federal title IV-E expenditures increased 492 percent (from $308.8 million to $1,828.5 million), outpacing inflation. Although the program has not been fully funded since 1981, funding for the title IV–B child welfare services program increased by 67 percent from 1981 to 1991 ($163.6 million to $273.9 million). Funding for the title XX social services block grant, which States may use for child welfare services, had actually fallen in nominal terms.

FEDERAL/NONFEDERAL CONTRIBUTION TO CHILD WELFARE EXPENDITURES

The American Public Welfare Association (APWA) recently conducted an analysis of 31 State child welfare services plans and found that these States planned to spend almost $3.5 billion for child welfare services in fiscal year 1990.[17] Of this total, the Federal Government was expected to contribute 42.6 percent (4.1 percent from title IV–B, 11.8 percent from title IV–E, and 26.7 percent from other Federal programs, including title XX). State plans indicated that the remaining 57.4 percent of child welfare costs would be paid by State, local or private sources.

State and other nonFederal spending is used to meet title IV–B and IV–E matching requirements, plus other child welfare costs such as 100 percent of the expense of maintaining non-AFDC-eligible foster children in substitute care.

The following two tables present information from the APWA analysis on categories of child welfare services and their funding sources. Table 38 indicates, for each category of service, the percentages of Federal and non-Federal funds spent. Table 39 indicates, for each funding source, the percentages spent on each category of service. Both tables are based on data from 31 States.

TABLE 38.—FUNDING SOURCES OF CHILD WELFARE SERVICES, FISCAL YEAR 1990

[In percentages, dollars in millions]

Category	Federal			State/local	Total percent	Total dollars
	IV–B [1]	IV–E [1]	Other [2]			
Preventive/supportive services	6.8	6.7	37.2	49.3	100.0	$897.7
Foster care maintenance	1.6	18.2	12.1	68.1	100.0	984.8
Foster care services	5.8	8.3	28.7	57.2	100.0	399.2
Adoption	3.5	20.6	10.5	65.4	100.0	166.9
Training/staff development	4.9	41.9	24.0	29.2	100.0	16.9
Administration	6.7	17.5	25.3	50.5	100.0	424.3
Other child welfare	4.1	3.8	35.8	56.3	100.0	172.4
Day care [3]	0.2	3.7	40.4	55.7	100.0	429.0
All services	4.1	11.8	26.7	57.4	100.0	3,491.3

[1] Federal dollars only; does not include nonFederal matching funds.

[2] Federal dollars only; does not include nonFederal matching funds. Includes title XX social services block grants.

[3] May include some employment and training related day care for children who are not necessarily clients of the child welfare system.

Source: APWA analysis of 31 State child welfare services plans, estimates of planned spending for fiscal year 1990.

---

[17] Testimony of John White, Apr. 4, 1990.

TABLE 39.—CHILD WELFARE SERVICES FUNDED BY FEDERAL/NONFEDERAL SOURCES, FISCAL YEAR 1990

[In percentages, dollars in millions]

Category	Federal			State/local	Percent of total
	IV–B [1]	IV–E [1]	Other [2]		
Preventive/supportive services	42.6	14.7	35.8	22.1	25.7
Foster care maintenance	11.1	43.6	12.8	33.4	28.2
Foster care services	16.3	8.0	12.3	11.4	11.4
Adoption	4.1	8.5	1.9	5.4	4.8
Training/staff development	0.6	1.7	0.5	0.3	0.5
Administration	19.9	18.1	11.5	10.7	12.2
Other child welfare	4.9	1.6	6.6	4.8	4.9
Day care [3]	0.5	3.9	18.6	11.9	12.3
Total percent	100.0	100.0	100.0	100.0	100.0
Total dollars	$143.2	$410.6	$931.6	$2,006.0	$3,491.3

[1] Federal funds only; does not include nonFederal matching dollars.

[2] Federal funds only; does not include nonFederal matching dollars. Includes title XX social services block grants.

[3] May include some employment and training related day care for children who are not necessarily clients of the child welfare system.

Source: APWA analysis of 31 State child welfare services plans, fiscal year 1990.

TITLE IV–E PLACEMENT, ADMINISTRATIVE AND TRAINING COSTS

In recent years an increasing proportion of title IV–E costs has been expended on what technically has been called administration and training. Table 40 shows that if current trends continue, at some point in the 1990s the amount expended on these "administrative costs" could be equal to the Federal reimbursement of States' title IV–E maintenance claims. The Congressional Budget Office (CBO) projects that this will take place approximately in fiscal year 1996.

In fiscal year 1981, on average 104,851 children were served each month by State programs funded under title IV–E at a Federal cost of $308.8 million, and by fiscal year 1990 these numbers had risen to 176,885 and $1.5 billion respectively. The most recent estimates from CBO project that the 1992 average monthly title IV–E caseload will be 217,000 at a Federal cost of $2.3 billion, rising to an estimated 297,000 and $4.2 billion respectively by 1996.

TABLE 40.—PROPORTION OF TITLE IV–E FOSTER CARE EXPENDITURES SPENT ON CHILD PLACEMENT, ADMINISTRATION AND TRAINING, FISCAL YEARS 1981–96 [1]

Fiscal year	Total Federal title IV–E expenditure (in millions)	Placement, administration and training expenditures (in millions)	Placement, administration and training proportion of total
Actual:			
1981	$308.8	$30.4	.10
1982	373.8	72.5	.19
1983	394.8	117.9	.30
1984	445.2	147.4	.33
1985	546.2	190.9	.35
1986	637.2	228.3	.36
1987	792.6	312.9	.39
1988	927.6	382.3	.41
1989	1,194.4	508.0	.43
HHS estimate:			
1990	1,476.9	633.1	.43
1991	1,828.6	818.4	.45
1992	2,222.7	1,049.9	.47
CBO estimate:			
1991	1,912.0	876.0	.46
1992	2,279.0	1,067.0	.47
1993	2,682.0	1,276.0	.48
1994	3,138.0	1,519.0	.48
1995	3,643.0	1,789.0	.49
1996	4,202.0	2,088.0	.50

[1] Does not include transfers to title IV–B.

Sources: Based on data from HHS and CBO.

The Department has argued that programs funded under title IV–E are becoming more expensive for the Federal Government because a growing number of States are transferring costs they had traditionally paid for themselves to the Federal Government as administrative expenses. During an April 1987 hearing of the House Select Committee of Children, Youth, and Families, Sydney Olsen, the Assistant Secretary for Human Development Services (HDS) testified "it appears that States are finding ways to refinance existing services through these entitlements and that the growth in administrative cost does not reflect increases in services or improved management." Assistant Secretary Olsen also expressed concern that the open-ended entitlement of title IV–E was being exploited by States which were hiring consultants to help them "capture" more available Federal funds. As evidence, the Department pointed to the high variability of title IV–E administrative and cost claims among States.

As is shown in table 6, in relation to each State's total expenditures, the proportion of title IV–E child placement and administrative costs varies widely. The nationwide average in fiscal year 1989 was 40 percent. Texas (75 percent), Virginia (66 percent), and Delaware (65 percent) claimed the highest proportion of their title IV-E spending for child placement and administration. Mississippi (4 percent), North Carolina (8 percent), and Hawaii (13 percent) had the lowest such proportions.

1987 AND 1990 HHS INSPECTOR GENERAL REPORTS

In October of 1987, the HHS Office of Inspector General published a report on the high absolute levels of title IV-E administrative and training costs and the wide variation of claims among States. The report found that the administrative costs associated with the foster care program are much higher than those associated with similar programs such as AFDC, and the Medicaid and Food Stamp programs. However, this was attributed to the fact that regulations implementing Public Law 96-272 expressly defined many activities as allowable administrative costs that were not reimbursed by the Federal Government when foster care was part of AFDC. By regulation, claimable title IV-E administrative costs include:

—referral to services at time of intake;
—preparation for, and participation in, judicial determinations;
—placement in foster care;
—development of a case plan;
—case reviews;
—case management and supervision;
—recruitment and licensing of foster homes and institutions; and
—foster care rate setting.

The 1987 report also found that much of the variation of States' administrative cost claims was linked to the degree of sophistication of each State's accounting practices. Not all States had sophisticated systems capable of documenting all allowable costs. Some other States chose to deliberately underclaim these expenses so that they could transfer unutilized funds to title IV-B child welfare services. The report concluded that some of the measures by which HHS documented the rapidly rising administrative costs associated with title IV-E were inappropriate:

> * * * some measures of relative State performance such as administrative cost per child and the ratio of administrative to maintenance costs better reflect charges to the Federal Government rather than the costs of running the program. Similarly, the use of percentage change in administrative cost to measure relative growth over time is complicated. Many States had an artificially low base in the early years (shortly after Public Law 96-272 was enacted) due both to their inability to claim all appropriate costs and the absence of required program components (page ii).

The 1987 report also stated that in seven separate studies HDS had failed to document that States were systematically transferring ineligible title IV-E administrative costs to the Federal Government. The report concluded that although HDS did uncover some random accounting errors "there was no evidence found to demonstrate patterns of abuse." In fact, OIG did an audit of the State of Missouri, in which claimed administrative costs had risen "precipitously" and found no serious State violations of Federal guidelines or regulations. The report also noted that HDS had presented no information to document how the consultant accounting and cost claim recommendations to States violated the regulations.

In addition, the report noted that the decision by the HHS Departmental Appeals Board (DAB) concerning the State of Missouri's title IV-E allowable administrative cost claims, which was issued shortly before the report's publication, would further expand the allowable expenses that could be charged as administration and training. It has been generally accepted that this has been the case, further strengthening the claim that administrative expenses include more than program "overhead." The Inspector General's office issued another report dated August 1990. The report presents the following specific findings, which generally tend to be consistent with the findings made in the 1987 report.

(1) The term "administrative costs" is a misnomer. Most of the activities being funded are not traditional administrative costs, but are "important child placement services". According to the IG report, administrative costs grew from $143 million in fiscal year 1985 to $400 million in fiscal year 1988. However, only 20 percent of the cost increase is attributable to administration of the program. Nearly 80 percent relates to direct service activities that the IG classified as "child placement services".

(2) The current procedure used to account for costs does not allow for examining any correlation between increased administrative costs and increased services to foster children.

(3) Cost increases occurred for two primary reasons: the expanded definition of allowable administrative activities provided in Public Law 96-272, and a broad interpretation of that definition by the Departmental Appeals Board. Other factors contributing to the increases were the States' use of consultants, a 19-percent increase in the number of title IV-E children, increases in the number of case workers, and cost-of-living increases for State employees.

(4) Variations in costs among States resulted from using nonhomogeneous cost indicators, a lack of uniformity in defining and allocating allowable costs, a gradual trend by States to use consultants for identifying opportunities to maximize Federal funding sources, and States' revision of cost allocation plans to capture costs for children who are "candidates" for IV-E foster care (but who may not ultimately receive foster care maintenance payments).

The report concludes that legislative and administrative measures are necessary for containing escalating administrative costs, and outlines various options.

1990 LEGISLATION RELATED TO ADMINISTRATIVE COSTS

During the second session of the 101st Congress, legislation was enacted as part of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) designed to provide better information on State reimbursement for administrative costs. Under the provisions of Public Law 101-508, "child placement services" is added as a separate category for which States may claim reimbursement, in addition to administrative costs. Prior to this provision, States claimed reimbursement for child placement services as administrative costs. The effect of the amendment, while not changing the type of services for which States may claim reimbursement, is designed to provide more specific information on how Federal matching funds are used.

FOSTER CARE AND ADOPTION DATA AND INFORMATION COLLECTION SYSTEM

LACK OF ADEQUATE DATA

Historically, there has been a serious lack of quality, reliable data in the area of foster care and adoption. In fact, all 50 States did not even report their average monthly foster care caseload under the federally assisted foster care maintenance program until 1975. States have never been required to collect statistics for non-federally-assisted foster care. A voluntary State reporting system in which not all States have chosen to participate fully exists for children provided foster care services under title IV–B child welfare services. The continued existence of this "information vacuum" severely complicates efforts to understand and define problems in the area of child welfare, and to fashion appropriate programmatic or legislative changes in response.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) was passed to address a number of concerns with the foster care and adoption services available in the States at that time. One of these was the lack of data on the number of children receiving services, including the length of time these children remained in care, the specific services provided, the cost of these services, and the demographic characteristics of the recipient population.

1980 INTERIM FINAL RULE

Shortly after Public Law 96–272 was enacted in 1980, HHS wrote a set of detailed regulations to guide State qualification for title IV–B incentive funds (each State's allotted share of appropriated funds in excess of $141 million). These regulations were published in the Federal Register on December 31, 1980 as an interim final rule. The regulations specified a number of State compliance requirements. These included a one-time inventory of the children in foster care to be conducted by each State, and the implementation of Statewide information systems to provide case-specific data on the children in foster care. Common data definitions were to be specified for use in all States.

Each State was required to establish a permanent Statewide information system for case tracking and policy formation purposes. It was specified that each system be able to readily determine at any point in time the location of all children who had been in care during the preceding 12 months, and provide both individualized case data and aggregated information conforming to uniform definitions developed by the Secretary of HHS. The data were to be transmitted within a time frame and in a format also specified by the Department.

However, this set of regulations never went into effect. On March 3, 1981, HHS withdrew the interim final rule, stating that the Office of Management and Budget (OMB) had not reviewed and approved the sections containing reporting and recordkeeping requirements. The following year the Department issued ACYF-PIQ-82-06. Primarily this policy information question simply restated the pertinent sections of title IV-B, which required States to have an information system. It did not specify the system's content. The 1980 regulations were never reissued.

PROBLEMS WITH THE CURRENT VOLUNTARY REPORTING SYSTEM

Currently, the only nationally aggregate data on the number and characteristics of children in foster care is voluntarily supplied by the States. Since 1982, the Voluntary Cooperative Information System (VCIS) has been administered by the American Public Welfare Association (APWA) under a grant from HDS. The data are in an annualized format. The VCIS data-gathering instrument requests that each State supply information on its foster care caseload, including the number in care at the beginning of the year, the number in care at the end, and the total number of children served during the year. However, when these data are observed in their raw form as submitted by States, it is evident that the VCIS numbers should only be viewed as rough estimates of the caseload. In many States entire sets of data are missing each year, or individual elements are missing from year to year, making aggregated yearly comparisons of these variables impossible. Moreover, reporting periods differ from State-to-State. For instance, some States adhere to the calendar year and others the fiscal year. In sum, no common definitions or census methodologies are utilized nationwide. In addition, since 1985 a serious time lag has developed between the time the data are gathered and published. The most recent, detailed VCIS data that are currently available date back to 1987.

Finally, the data currently collected are of limited use. Primarily, this stems from the fact that they are only available in an aggregated State-specific format. Because case-specific information is not available, common configurations of service utilization by specific segments of the foster care population cannot be obtained, and it is impossible to track a case through the system in a longitudinal manner. The absence of these two analytical functions makes it difficult to evaluate the effectiveness of specific policy strategies. For instance, from the data available it cannot be determined whether particular reunification strategies for abused or abandoned infants do, or do not, lead to higher substitute care reentry rates over the course of their lifetime, or whether in the long run family preservation programs actually reduce the need for foster care placement. Although the VCIS has gathered States' estimates of the proportion of their caseload reentering foster care, this statistic does not accurately address the service strategy and programmatic issues raised above.

ENACTMENT OF 1986 REPORTING REQUIREMENTS

In recognition of these problems, in 1986 Congress approved an amendment (included in Public Law 99-509, the Omnibus Budget Reconciliation Act) to title IV-E (section 479), requiring that an advisory committee be formed to submit a report to Congress and the

Secretary of HHS making recommendations with respect to methods of establishing, administering, and financing a system for the collection of data on adoption and foster care in the United States. Specifically the advisory committee was charged with:

—identifying the types of data necessary to assess on an ongoing basis the incidence, characteristics, and status of the system of adoption and foster care nationwide, and developing appropriate national policies in this area;

—evaluating the feasibility and appropriateness of collecting data with respect to privately arranged adoptions that did not have assistance from public welfare agencies; and

—assessing the validity of various methods of collecting adoption and foster care data, and determining the financial and administrative impact of implementing each option.

The legislation specified that the Secretary of HHS must issue final regulations for the system by December 31, 1988, and that mandatory data collection must be fully implemented no later than October 1, 1991. The Department published its proposed regulations in the Federal Register on September 27, 1990.

DATA ADVISORY COMMITTEE RECOMMENDATIONS AND HHS RESPONSE

The final report issued by the advisory committee in 1987 included detailed recommendations for a new mandatory foster care and adoption data collection system. The report proposed that data on all foster children under the purview of section 427 (defines the content of case record reviews) of title IV–B be collected, including children who exited care before their case record was reviewed. This would include children placed under the auspices of public child welfare agencies, those placed by private agencies contracting with public agencies, as well as children placed by private agencies in licensed, private facilities. The advisory committee also recommended that data be collected on all legally adopted children, including relative and nonrelative placements, under the auspices of both public and private agencies. It was recommended that children served by related service systems (such as those providing mental health, juvenile justice, and developmental disability services), and children in unlicensed foster care settings not be included in the data collection system.

It was proposed that the foundation of the data collection system rest on individual case data on each child, including demographic information (such as gender, age, ethnicity, number of siblings etc.); information on the child's biological, foster, and adoptive parents; current placement information as well as previous stays in substitute care (including type of placement, placement goal, service delivery, duration of care, and funding sources); and information on the placement outcome of children leaving substitute care. States would submit data quarterly to ACYF, and the data would be kept confidential.

Under the advisory committee recommendations, ACYF would be required to generate annual reports on the data to coincide with the Federal fiscal year. The information identified by the advisory committee was selected because it parallels that which is useful to States administering foster care and adoption services on a day-today basis. This information, supplemented with reports compiled from data at a national level, would be collected for direct policy application by States, localities, and the Federal government.

The advisory committee also recommended that the Federal government cover all expenses associated with system startup and development in each State through September 30, 1991, including costs for computer hardware and software acquisition, staff training, and the development of new reporting forms under the advisory committee's recommendations, beginning in fiscal year 1989. Federal technical assistance to States should also be available in these areas. The committee recommended that ongoing operational costs of the system be reimbursed at 50 percent Federal matching of State fund expenditures. If necessary, penalties would be levied against States that did not comply with the reporting requirements by the system implementation target date. It was recommended that a separate office in ACYF be created to plan and implement the data collection system.

In May 1989, HHS responded to the advisory committee report by issuing a report to Congress on its plan for implementation of the system. The system proposed by the Secretary of HHS differed from the advisory committee recommendations in two primary areas: the population to be included in the data collection system, and the method by which system startup would be financed. The Department proposed that the target population only encompass children served directly under the responsibility of a State child welfare agency, including all children placed by private agencies under contract with a public agency, but excluding children placed privately by private licensed facilities. Similarly, the adoption population to be included would be limited to adoptions that involve a State agency, and would exclude children placed by private agencies. Data on private adoptions would be reported voluntarily by States. The HHS report also proposed that States bear much of the costs associated with system startup by utilizing existing title IV-B funds, and claiming costs to the extent allowed as title IV-E administrative and training expenditures.

On September 27, 1990 HHS published proposed regulations in the Federal Register to implement the data collection system. The HHS proposal was based largely on the HHS Report of May 1989. The population to be covered by HHS proposal would be children under the responsibility of the State child welfare agency, and financing for the system would be available through the title IV-E administrative cost match. However, States would be able to claim only that portion of their data collection costs that relate to children eligible for title IV-E, although the data collection system would be required to cover non-IV-E children as well.

The deadline for submitting comments on HHS' proposed regulations was December 26, 1990.

Section 12. Tax Expenditures and Other Tax Provisions Related to Retirement, Health, Poverty, Employment, and Disability

INTRODUCTION

A significant portion of the Federal budget consists of direct payments to individuals for retirement, health, public assistance, employment, and disability benefits provided pursuant to entitlement programs. Such programs include: Social Security, veterans' pensions, Medicare, Medicaid, food stamps, Aid to Families with Dependent Children, and Supplemental Security Income.

One may also view the Federal Government as providing indirect payments to individuals, by means of special income tax deductions, exclusions, and credits related to health and other social policy objectives. These expenditures through the tax system (so-called tax expenditures) are described in this section.

CONCEPT OF TAX EXPENDITURES

Tax expenditure estimates measure the decreases in individual and corporate income tax liabilities that result from provisions in income tax laws and regulations that provide economic incentives or tax relief with respect to particular activities to particular kinds of taxpayers. These tax provisions take the form of exclusions, credits, deductions, preferential tax rates, and deferrals of tax liability.[1]

The term "tax expenditure" reflects the assumption that the goals of these favorable tax provisions in many cases could be accomplished by replacing them with direct expenditure programs. Tax expenditures can be viewed as entitlement programs—spending programs that are not subject to the annual appropriations process and that are available as entitlements to eligible individuals and corporations. Tax expenditure provisions, unlike direct spending programs, are administered by the Internal Revenue Service.

The definition of tax expenditures used in this report is consistent with the Congressional Budget Act: i.e., "* * * those revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption or deduction from gross income or which provide a special credit, a preferential rate of tax or a deferral of tax liability." The legislative history of the Act indicates that tax expenditures are to be defined with reference to a normal income tax structure.[2] The measurement of tax expenditures is discussed at the end of this section.

---

[1] Tax expenditure information is provided in annual publications of the Joint Committee on Taxation and in the President's budget. Table XI-1 of the budget contains an estimate of the outlay equivalent and the revenue loss from each tax expenditure. The House and Senate Budget Committees publish tax expenditure revenue loss estimates in their reports that accompany budget resolutions reported to their respective Houses.

TAX EXPENDITURE ESTIMATES

The revenue loss in fiscal year 1992 attributable to tax expenditures related to retirement, health, poverty, employment, and disability is estimated to be $162.0 billion (see table 1).[3] Tax expenditures related to retirement and health comprise $140.4 billion of this amount, or 87 percent. By comparison, the Congressional Budget Office estimates that outlays for Social Security, veterans' pensions, Medicare, and Medicaid will be to $474 billion in fiscal 1992, representing over 68.9 percent of projected outlays for entitlements and other mandatory spending, not including deposit insurance outlays.[4]

---

[2] As defined in the Congressional Budget Act, the concept of tax expenditures refers to the corporate and individual income taxes. Federal excise, employment, and estate and gift taxes also have exceptions, exclusions, refunds and credits, which are not included in this section.

[3] Each tax expenditure item is measured without regard to other items. Thus, the addition of various tax expenditure items may be misleading (see discussion of tax expenditure measurement at the end of this section).

[4] CBO, "The Economic and Budget Outlook: Fiscal Years 1992-1996," (January 1991), p. 91.

TABLE 1.—TAX EXPENDITURE ESTIMATES: FISCAL YEARS 1992–96

[Billions of dollars]

Item	1992	1993	1994	1995	1996
Tax expenditures related to retirement:					
Net exclusion of pension contributions and earnings	54.0	57.0	59.0	61.0	64.0
Keogh plans	2.9	3.0	3.2	3.4	3.6
Individual retirement plans	6.2	6.5	6.9	7.3	7.8
Exclusion of Social Security and railroad retirement benefits [1]	25.6	27.0	28.4	29.9	31.4
Tax expenditures related to health:					
Exclusions of employer contributions for medical insurance premiums and medical care	37.7	41.3	45.1	49.0	53,2
Exclusion of Medicare benefits:					
Medicare Part A	7.1	7.7	8.3	9.0	9.8
Medicare Part B	4.0	4.5	5.0	5.7	6.4
Deductibility of medical expenses	2.9	3.3	3.8	4.4	5.0
Tax expenditures related to poverty:					
Earned income tax credit:					
Nonrefundable portion	.9	.9	1.2	1.4	1.5
Refundable portion	7.8	8.5	10.6	12.3	13.2
Credit for child medical insurance premiums:					
Nonrefundable portion	.1	.1	.1	.1	.1
Refundable portion	.5	.6	.6	.7	.7
Exclusion of public assistance and SSI cash benefits	.4	.4	.4	.4	.5

Tax expenditures related to employment:					
Dependent care credit	3.1	3.3	3.4	3.5	3.7
Exclusion of employer-provided dependent care	.3	.4	.5	.5	.6
Targeted jobs tax credit	.2	.1	(2)	(2)	(2)
Employee stock ownership plans (ESOPs)	.9	1.0	1.1	1.2	1.2
Exclusion for benefits provided under cafeteria plans	2.6	2.9	3.1	3.2	3.3
Tax expenditures related to elderly and disabled:					
Exclusion of workers' compensation and special benefits for disabled coal miners:					
Workers' compensation	2.9	3.1	3.2	3.4	3.6
Special benefits for disabled coal miners	.1	.1	.1	.1	.1
Additional standard deduction for elderly and blind	1.7	1.8	1.9	1.9	2.0
Tax credit for elderly and disabled	.1	.1	.1	.1	.1
Tax expenditures related to housing:					
Deductibility of mortgage interest	38.8	42.2	45.9	50.0	54.4
Deferral of capital gain on sale of principal residence	11.5	12.1	12.7	13.6	15.5
Exclusion of capital gain on sale of residence of persons 55 and over	3.8	4.0	4.2	4.5	5.2
Low-income housing tax credit	1.1	1.1	1.1	1.1	1.1
Total	217.2	233.0	249.9	267.7	288.0

---

[1] In addition to OASI benefits for retired workers, these figures also include disability insurance benefits, and benefits for dependents and survivors.

[2] Less than $50 million.

Source: Joint Committee on Taxation.

NET EXCLUSION OF PENSION CONTRIBUTIONS AND EARNINGS

Legislative history

Prior to 1921, no special tax treatment applied to employee retirement trusts. Retirement payments to employees and contributions to pension trusts were deductible by the employer as an ordinary and necessary business expense. Employees were taxed on amounts actually received as well as on employer contributions to a trust if there was a reasonable expectation of benefits accruing from the trust.

Since 1921, in order to stimulate the adoption of retirement plans by employers, the Internal Revenue Code has specifically provided that certain employee trusts are exempt from Federal income tax. The 1921 Code provided an exemption for a trust forming part of a qualified profit-sharing or stock bonus plan. The 1926 Code provided a similar exemption for qualified pension trusts and established deduction limits to limit the extent to which tax-favored treatment would be available under qualified plans. A number of changes to the qualification rules and deduction limits were made prior to the enactment of the 1954 Code.

The special tax treatment afforded employee trusts was retained in the 1954 Code. Section 401(a) (and sections referred to therein) contains the basic qualification standards which a trust must satisfy in order to be exempt from tax under section 501(a); section 404 limits the amount of contributions that can be deducted; and sections 402 and 72 govern the taxation of benefits distributed to employees.

The standards applicable to qualified plans have been revised over time to reflect Congressional concerns related to the expansion of pension, profit-sharing, and stock bonus plans and the prevention of tax abuses. The rules relating to qualified plans were substantially revised by the Employee Retirement Income Security Act of 1974 (ERISA), which added minimum participation, coverage, vesting, benefit accrual, and funding requirements, and overall limits on contributions and benefits. Further revisions of these rules were made by the Tax Reform Act of 1976, the Revenue Act of 1978, the Multiemployer Pension Plan Protection Act of 1980, the Economic Recovery Tax Act of 1981, the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Reduction Act of 1984, the Retirement Equity Act of 1984, the Tax Reform Act of 1986, the Consolidated Omnibus Budget Reconciliation Act of 1986, the Omnibus Budget Reconciliation Act of 1987 (including the Pension Protection Act), the Omnibus Budget Reconciliation Act of 1989 and the Omnibus Budget Reconciliation Act of 1990.

Prior to the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), different rules applied to retirement plans maintained by incorporated employers and unincorporated employers (such as partnerships). In general, plans maintained by unincorporated employers were subject to special rules in addition to the other qualification requirements of the Code. TEFRA generally eliminated this disparity and applied the same rules to qualified plans without regard to whether or not the employer is incorporated. TEFRA also modified the limits on contributions and benefits applicable to tax-qualified retirement plans.

The Retirement Equity Act of 1984 (REA) reflected Congressional concern that the prior-law qualification rules did not adequately reflect changing work patterns of workers and their spouses, and did not provide adequate protection for the surviving spouse of a worker. REA made a number of changes to the qualification rules designed to increase the rights of workers and their spouses including modifications of the minimum participation requirements, the rules relating to what service must be taken into account for purposes of vesting and benefit accrual (including special rules relating to maternity or paternity leave), the rules relating to spousal survivor benefits, the distribution of qualified plan benefits upon divorce, and the protection of accrued benefits.

The Tax Reform Act of 1986 made substantial modifications to the limits on deductions for contributions to qualified plans, tax treatment of distributions from such plans, and the qualification rules. These provisions reflect continued Congressional concern that the special tax benefits for qualified plans should only be available if retirement benefits are provided on a nondiscriminatory basis, the benefits are within certain limits, and the benefits are generally used for retirement purposes.

The Omnibus Budget Reconciliation Act of 1987 (including the Pension Protection Act) modified the minimum funding requirements applicable to single-employer defined benefit pension plans and the maximum amount that may be deducted for contributions to such plans. These changes were designed to eliminate excessive overfunding and underfunding of defined benefit pension plans.

Since ERISA, Congress has also acted to broaden the range of qualified plans. In the Revenue Act of 1978, Congress permitted and provided special rules for qualified cash or deferred income arrangements under section 401(k). Under these arrangements, known popularly as 401(k) plans, employees can elect to receive cash or have their employers contribute a portion of their earnings to a qualified profit sharing, stock bonus, or pre-ERISA money purchase pension plan. An employee stock ownership plan (ESOP) is a special type of qualified plan that is designed to invest primarily in securities of the employer maintaining the plan. ESOPs serve as a tool of corporate finance as well as a retirement plan. Certain qualification rules and tax benefits apply to ESOPs that do not apply to other types of qualified plans. The special tax benefits for ESOPs were significantly expanded by the Deficit Reduction Act of 1984.

The Omnibus Budget Reconciliation Act of 1989 modified the special tax benefits for ESOPs. These changes reflected congressional concerns that the use of the tax benefits accorded ESOPs had extended beyond their intended purpose and that the revenue loss associated with these tax benefits had increased beyond the originally anticipated loss, without a corresponding benefit to employees.

The Omnibus Budget Reconciliation Act of 1990 increased the excise tax on plan assets recovered by an employer in an asset reversion upon termination of a defined benefit plan.

Explanation of provision

In general.—Under a plan of deferred compensation that meets the qualification standards of the Internal Revenue Code (a qualified plan), an employer is allowed a deduction for contributions (within the limits of sec. 404) to a tax-exempt trust to provide employee benefits. Similar rules apply to plans funded with annuity contracts. An employer that makes contributions to a qualified plan in excess of the deduction limits is subject to a 10-percent excise tax on such excess (sec. 4972). In the event of a termination of a defined benefit pension plan, any assets remaining after satisfaction of the plan's liabilities may revert to the employer. Such reversions are included in the gross income of the employer and are subject to income tax plus an additional excise tax payable by the employer. The excise tax is 20 percent if the employer establishes a qualified replacement plan, or provides certain benefit increases. Otherwise, the excise tax is 50 percent of the reversion.

The qualification rules for pension, profit-sharing, and stock bonus plans are contained in section 401(a) and sections referred to therein. These rules limit the amount of benefits that can be provided through a qualified plan, and require that benefits be provided on a basis that does not discriminate in favor of highly compensated employees. In addition, qualified plans are required to meet minimum standards relating to participation (the restrictions that may be imposed on participation in the plan), coverage (the portion of employees participating in the plan), vesting (the time at which an employee's benefit becomes nonforfeitable), and benefit accrual (the rate at which an employee earns a benefit). Also, minimum funding standards apply to the rate at which employer contributions are required to be made to the plan to ensure the solvency of pension plans.

Minimum participation rules.—A qualified plan generally may not require as a condition of participation that an employee complete more than one year of service or be older than age 21 (sec. 410(a)).

Vesting rules.—A plan is not a qualified plan unless a participant's employer-provided benefit vests at least as rapidly as under one of two alternative minimum vesting schedules (sec. 411). A plan satisfies the first schedule if a participant has a nonforfeitable right to 100 percent of the participant's accrued benefit derived from employer contributions upon the participant's completion of 5 years of service. A plan satisfies the second schedule if a participant has a nonforfeitable right to at least 20 percent of the participant's accrued benefit derived from employer contributions after 3 years of service, 40 percent after 4 years of service, 60 percent after 5 years of service, 80 percent after 6 years of service, and 100 percent after 7 years of service.

Benefit accrual rules.—The protection afforded employees under the minimum vesting rules depends not only on the minimum vesting percentages, but also on the accrued benefits to which these percentages are applied. In the case of a defined contribution plan, the accrued benefit is the participant's account balance. In the case of a defined benefit plan, a participant's accrued benefit is determined under the plan benefit formula, subject to certain restrictions. In general, the accrued benefit is defined in terms of the benefit payable at normal retirement age and does not include certain ancillary nonretirement benefits.

Each defined benefit plan is required to satisfy one of three accrued benefit tests. The primary purpose of these tests is to prevent undue backloading of benefit accruals (i.e., by providing low rates of benefit accrual in the employee's early years of service when the employee is most likely to leave and by concentrating the accrual of benefits in the employee's later years of service when he or she is most likely to remain with the employer until retirement).

Coverage rules.—A plan is not qualified unless the plan satisfies at least one of the following coverage requirements: (1) the plan benefits at least 70 percent of all nonhighly compensated employees, (2) the plan benefits a percentage of nonhighly compensated employees that is at least 70 percent of the percentage of highly compensated employees benefiting under the plan, or (3) the plan meets the average benefits test (sec. 410(b)). A plan meets the average benefits test if (1) the plan benefits such employees as qualify under a classification set up by the employer and found by the Secretary of the Treasury not to discriminate in favor of highly compensated employees, and (2) the average benefit percentage for nonhighly compensated employees of the employer is at least 70 percent of the average benefit percentage for highly compensated employees of the employer.

In addition, a plan is not a qualified plan unless it benefits the lesser of (1) 50 employees or (2) 40 percent of the employees of the employer (sec. 401(a)(26)).

General nondiscrimination rule.—In general, a plan is not a qualified plan if the contributions or benefits under the plan discriminate in favor of highly compensated employees (sec. 401(a)(4)). A plan is not considered discriminatory under this provision if the contributions or benefits bear a uniform relationship to compensation or if the contributions or benefits are integrated with social security benefits in accordance with certain rules (secs. 401(a)(5), 401(l)).

Limitations on contributions and benefits.—The maximum annual benefit that may be provided by a defined benefit pension plan (payable at the social security retirement age) is the lesser of (1) 100 percent of average compensation, or (2) $108,963 (for 1991) (sec. 415(b)). The dollar limit is adjusted annually for cost of living increases. The dollar limit is reduced if payments of benefits begin before the social security retirement age, and increased if benefits begin after the social security retirement age.

The maximum annual addition that can be made to a defined contribution plan is the lesser of (1) 25 percent of compensation, or (2) $30,000 (sec. 415(c)). Cost of living adjustments will be made to the $30,000 limit when it equals one-fourth of the dollar limit applicable to defined benefit pension plans.

An overall limit applies if an individual participates in both a defined contribution plan and a defined benefit plan of the same employer (sec. 415(e)).

Funding rules.—Pension plans are required to meet a minimum funding standard for each plan year (sec. 412). In the case of a defined benefit pension plan, the minimum funding rules generally require that an employer contribute an annual amount sufficient to fund a portion of participants' projected benefits determined in accordance with one of several prescribed funding methods, using reasonable actuarial assumptions. In addition, defined benefit pension plans with funded ratios of less than 100 percent are subject to additional, faster funding rules (sec. 412(l)).

Taxation of distributions.—Under sections 402 and 72, an employee who participates in a qualified plan is taxed when the employee receives a distribution from the plan (to the extent the distribution is not attributable to employee contributions). With certain exceptions, a 10-percent additional income tax is imposed on early distributions from a qualified plan. A 15-percent excise tax is imposed on distributions which exceed a certain amount in any year (sec. 4980A).

Failure to satisfy qualification requirements.—If a plan fails to satisfy the qualification requirements, the trust holding plan assets is not tax-exempt, an employer's deduction for plan contributions is allowed when the employee includes the contributions or benefits in income, and benefits generally are includible in an employee's income when they are no longer subject to a substantial risk of forfeiture.

Effect of provision

The tax treatment of pension contributions and earnings has encouraged employers to establish qualified retirement plans and to compensate employees in the form of pension contributions to such plans. The tax advantage of being compensated through pension contributions consists of two parts. One advantage can be thought of as the ability to earn tax-free returns to saving. The following example illustrates this principle.

Suppose an employee is always taxed at a 15-percent marginal rate.[5] If the employer makes a one-time payment of $1,000 into a qualified pension plan for the employee, the employee immediately saves the $150 in tax that would have been paid if the employee received cash compensation. If the plan earns 8 percent per year, and the contribution and earnings are not taxed until they are withdrawn, after 10 years, the principal and accumulated earnings would total $2,158.93. The tax due on this amount is $323.84, which is exactly equal to the original $150 of tax saved plus 10 years of compounded interest at an 8 percent rate. After the 15-percent tax, $1,835.09 would be available to the employee. Note that this is equivalent to the employee receiving $1,000 cash compensation and paying the $150 tax and then investing the remaining $850 at an 8-percent rate of return, since that would leave $1,835.09 after ten years.

If, on the other hand, the employer compensated the employee with cash instead (taxable income to the employee), and the annual earnings had been taxed as earned (with the rate of return being the same 8 percent rate), the employee would have invested $850, but would have only $1,641.09 accumulated in the account at the end of 10 years. This is equivalent to the employee earning a rate of return equal to 6.8 percent (which is the 8 percent rate of return after the 15 percent income tax). Thus, when saving is done through a pension plan, the employee earns a higher rate of return than on fully-taxed saving.[6]

---

[5] This calculation ignores the fact that when an employee is compensated in the form of pension contributions (other than 401(k) plan contributions), both the employee's and the employer's share of the payroll tax are avoided, creating another tax advantage for pension contributions over cash compensation. For employees earnings more than the Social Security tax ceiling ($53,400 in 1991), the avoidance of the payroll tax does not provide a tax advantage to the employee-employer pair. For employees earning less than the payroll tax ceiling, the value of this tax advantage is difficult to measure, because while the payroll tax is avoided, compensation in the form of pension contributions is not taken into account for the calculation of Social Security benefits.

There may also be a second advantage to employees being compensated with qualified pension plan contributions instead of in taxable cash. If an employee's tax rate is lower in retirement than during the working years, then deferring payment of the tax on the contribution is even more valuable than the example above suggests.

These tax provisions directly benefit only persons who work for employers with qualified plans, and who work for a sufficient period of time to vest in such plans. The current extent of this coverage and recent trends in coverage are described below.

Coverage

The term covered, as used here, means that an employee is accruing benefits in an employer pension or other retirement plan. Other retirement plans are profit-sharing or stock bonus plans; the term pensions is used here to refer to all such plans. The best current comprehensive evidence on pension coverage comes from the 1988 Survey of Employee Benefits, a supplement to the May 1988 Current Population Survey. The data referred to below come from that survey unless otherwise noted. Although respondents to the survey were not asked whether their plans were qualified, nearly all persons with a pension are in qualified plans. Thus, the information may be interpreted as applying to qualified plans.

As of May 1988, 48 percent of full-time wage and salary workers employed in the private sector reported that they were covered by an employer-sponsored pension. Most of these workers were covered by basic defined benefit or defined contribution plans (31 percent), and another 8 percent had both a basic plan and a 401(k) type contributory plan (see table 2).[7] For another 9 percent, the 401(k) type plan was their only retirement plan. Most employers contributed to their 401(k) type plan, but 1 to 2 percent of workers with only a 401(k) plan also reported that their employer did not contribute to their plan. Thus while 48 percent of full-time workers in private employment had employer-sponsored plans, 46 percent had employer-financed plans.[8]

---

[6] This discussion applies to pension contributions made by employers. Employees may also be able to contribute to qualified plans. However, employee contributions are made with after-tax dollars. The tax advantage given to these contributions is smaller than the tax advantage given to employer contributions, and consists of the deferral of tax on accumulated earnings.

[7] Some private-sector employees contribute to 403(b) tax-sheltered annuities instead of 401(k) plans.

[8] Table 2 shows only 1 percent of workers with 401(k) type plans who have no employer contribution while the text refers to 48 percent of employees in employer-sponsored plans and 46 percent in employer-financed plans. The discrepancy is due to rounding.

TABLE 2.—COVERAGE UNDER EMPLOYER-SPONSORED PENSION OR RETIREMENT PLANS: PERCENT DISTRIBUTION OF FULL-TIME PRIVATE WAGE AND SALARY WORKERS AGED 16 OR OLDER

Coverage status	Total	Men	Women
Number of private wage and salary workers aged 16 or older (in thousands)	71,485	43,188	28,296
Employer-sponsored plan	48	51	44
Basic pension only	31	33	29
Basic and 401(k) type	8	9	8
401(k) type only	9	9	8
Employer contributes	7	7	7
Employer does not contribute	1	2	1
Not covered	51	48	55
Don't know	1	1	1

Source: John R. Woods, "Pension Coverage Among Private Wage and Salary Workers: Preliminary Findings From the 1988 Survey of Employee Benefits," Social Security Bulletin, 52:10 (October 1989), p. 8.

Pension coverage varies substantially among full-time, privately employed workers. Differences depend on the age of the worker, job earnings, the industry of employment, the size of the firm, and whether the worker is represented by a union.

Younger workers are much less likely to be covered by a pension than middle-aged and older workers. Coverage rates rise steadily from 12 percent for those under age 21 to almost 60 percent for those aged 40 or over. This pattern holds for both men and women. However, the jump in coverage for middle-aged men is about 10 percentage points larger than the increase for middle-aged women (see table 3).

TABLE 3.—PERCENT COVERED UNDER EMPLOYER-FINANCED PENSION OR RETIREMENT PLAN BY AGE AND SEX: FULL-TIME PRIVATE WAGE AND SALARY WORKERS AGED 16 OR OLDER

Age (in years)	Total	Men	Women
Total	46	49	43
Under 21	12	12	11
21 to 25	25	24	26
25 to 29	42	41	42
30 to 34	48	48	48
35 to 39	54	57	49
40 to 44	57	61	51
45 to 49	56	61	49
50 to 54	58	63	49
55 to 59	56	60	49
60 or older	47	51	40

Source: John R. Woods, "Pension Coverage Among Private Wage and Salary Workers: Preliminary Findings From the 1988 Survey of Employee Benefits," Social Security Bulletin, 52:10 (October 1989), p. 10.

Higher paying jobs are more likely to include pensions. Just 13 percent of workers earning less than $10,000 per year are covered compared to 72 percent for those earning $50,000 or more (see table 4). Coverage may be higher for higher paying jobs because of the greater value of the pension tax benefits to workers in higher tax brackets, and because of the declining replacement rate of Social Security at higher earnings levels. The similarity in coverage between men and women with the same earnings, shown in table 4, suggests that the higher overall coverage rate among men is due to their greater representation in higher paying jobs.

TABLE 4.—PERCENT COVERED UNDER EMPLOYER-FINANCED PENSION OR RETIREMENT PLAN BY ESTIMATED 1988 EARNINGS: FULL-TIME PRIVATE WAGE AND SALARY EMPLOYEES AGE 16 OR OLDER

Earnings	Total	Men	Women
Total [1]	46	49	43
Under $10,000	13	12	13
$10,000 to $14,999	33	27	39
$15,000 to $19,999	47	43	51
$20,000 to $24,999	58	57	60
$25,000 to $29,999	66	65	68
$30,000 to $39,999	72	71	73
$40,000 and over	72	72	73

[1] Total includes workers not responding on earnings, not shown separately.

Source: Social Security Administration tabulations from 1988 Survey of Employee Benefits, supplement to May 1988 Current Population Survey.

Industries with high pension coverage include manufacturing, mining, financial services, and transportation and public utilities. Coverage rates are nearly 60 percent in each of these industries (see table 5). In contrast, coverage rates are under 30 percent in agriculture, retail trade, and services other than financial and professional. Part of the difference among industries appears to be due to differences in firm size. Coverage is much lower for smaller firms as smaller firms are less likely to offer comprehensive fringe benefit packages as part of total compensation. Only 11 percent of full-time workers in firms with fewer than 10 employees are covered. The rate rises with employer size but does not reach the 46 percent average rate until firms have 250 or more employees (table 6). Workers represented by a union are also more likely to be covered under a pension than are other workers. Seventy-five percent of those represented by a union are covered compared to 43 percent of those without a union. Union representation is particularly important in coverage among small employers.

TABLE 5.—PERCENT COVERED UNDER EMPLOYER-FINANCED PENSION OR RETIREMENT PLANS BY INDUSTRY: FULL-TIME PRIVATE WAGE AND SALARY WORKERS AGED 16 AND OLDER

Industry	Total	Men	Women
Total [1]	46	49	43
Agriculture	12	13	11
Mining	63	62	72
Construction	30	31	24
Manufacturing:			
Durable goods	64	65	62
Nondurable goods	59	65	50
Transportation and public utilities	59	58	63
Trade:			
Wholesale	48	52	38
Retail	29	31	28
Finance, insurance, and real estate	57	57	58
Services:			
Professional	45	50	41
Other services	24	27	19

[1] Total includes workers in forestry and fisheries industries not shown separately.

Source: John R. Woods, "Pension Coverage Among Private Wage and Salary Workers: Preliminary Findings From the 1988 Survey of Employee Benefits," Social Security Bulletin, 52:10 (October 1989), p. 13.

TABLE 6.—PERCENT COVERED UNDER EMPLOYER-FINANCED PENSION OR RETIREMENT PLANS BY SIZE OF FIRM: FULL-TIME PRIVATE WAGE AND SALARY WORKERS AGED 16 AND OLDER

Firm size (number of workers)	Total	Men	Women
Total [1]	46	49	43
Fewer than 10	11	12	9
10 to 24	22	22	20
25 to 49	29	33	23
50 to 99	40	43	35
100 to 249	45	49	39
250 or more	67	71	63

[1] Total includes workers for whom firm size is unknown, not shown separately.

Source: John R. Woods, "Pension Coverage Among Private Wage and Salary Workers: Preliminary Findings From the 1988 Survey of Employee Benefits," Social Security Bulletin, 52:10 (October 1989), p. 15.

Significant differences in coverage also are apparent between full-time private wage and salary workers and other wage and salary workers. Coverage is much lower among part-time workers and much higher among public employees.

Trends in coverage

At the outset of World War II, private employer pensions were offered by about 12,000 firms. Pensions spread rapidly during and after the war, encouraged by high marginal tax rates and war-time wage controls that exempted pension benefits. By 1972, when the first comprehensive survey was undertaken, 48 percent of full-time private employees were covered. Subsequent surveys found that coverage reached 50 percent in 1979, but by 1983 had fallen back to 48 percent. The decline continued in the 1980's, reaching 46 percent in 1988 (see table 7).

TABLE 7.—PERCENT COVERED UNDER EMPLOYER-FINANCED PENSION OR RETIREMENT PLAN BY YEAR: FULL-TIME PRIVATE WAGE AND SALARY WORKERS AGED 16 OR OLDER

Year	Total	Men	Women
1972	48	54	38
1979	50	55	40
1983	48	52	42
1988	46	49	43

Source: John R. Woods, "Pension Coverage Among Private Wage and Salary Workers: Preliminary Findings From the 1988 Survey of Employee Benefits," Social Security Bulletin, 52:10 (October 1989), p. 17.

The decline in coverage in the 1980's is concentrated among younger men. The coverage rate of those aged 16 to 24 has fallen 9 percentage points since 1979; the rate of those aged 25 to 29 has fallen 12 percentage points, and the rate of those aged 30 to 34 has fallen 14 percentage points. The coverage rate among older men has fallen less dramatically, and among women it has risen at some ages and fallen at others. Explanations for the decline in coverage among young men include the shifting of employment shares from manufacturing to services, and the declining share of employees represented by a union contract. Both of these affect men more than women and new job entrants more than long-tenured workers.

The decline in pension coverage has occurred at the same time that employers have been shifting from defined benefit plans, a shift that has accelerated since 1980. According to Department of Labor data, defined benefit plans provided basic plan coverage for 87 percent of private wage and salary workers in 1975.[9] This dropped to 83 percent by 1980 and to 71 percent by 1985. This shifting composition has largely been the result of rapid growth in primary defined contribution plans, a growth rate that has been more than twice that of the total labor force. In contrast, the number of workers in basic defined benefit plans has changed little since 1975 in spite of the growth of the labor force. Employee stock ownership plans and 401(k) plans have been among the most rapidly growing defined contribution plans. Employers' shifting choice of plan type, as well as the choice of whether to provide any plan, has probably been influenced by the changing composition of working families, job mobility, and the increasing complexity and more careful benefit targeting required of qualified plans.

---

[9] John A. Turner and Daniel Beller, eds., "Trends in Pensions," the Department of Labor, 1989, p. 65, 357.

INDIVIDUAL RETIREMENT PLANS

Legislative history

The Employee Retirement Income Security Act of 1974 (ERISA) added section 219 of the Internal Revenue Code, providing a tax deduction for certain contributions to individual retirement arrangements (IRAs) and permitting the deferral of tax on amounts held in such arrangements until withdrawal. Active participants in employer plans were not permitted to make deductible IRA contributions.

In response to concerns that active participants in employer plans often received inadequate retirement benefits, the Economic Recovery Tax Act of 1981 (ERTA) eliminated the provision restricting IRA eligibility to individuals who were not active participants. In addition, ERTA increased the amount of the permitted deduction.

The Tax Reform Act of 1986 amended section 219 (beginning in 1987) to provide that the full IRA deduction is not available to individuals with income above certain levels who are active participants in an employer-maintained retirement plan (or, in the case of a joint return, where the spouse is an active participant). Individuals who are not entitled to the full IRA deduction may make nondeductible contributions to an IRA.

Explanation of provision

An individual is permitted to make deductible IRA contributions up to the lesser of $2,000 ($2,250 for an individual with a nonworking spouse or a spouse who elects to be treated as a nonworking spouse) or 100 percent of compensation (earned income in the case of a self-employed individual) if (1) the individual (or a couple, if a joint return is filed) has adjusted gross income ("AGI") that does not exceed an applicable dollar amount, or (2) the individual is not an active participant in an employer plan (or, in the case of married individuals, neither the individual nor the individual's spouse is an active participant). The applicable dollar amount is (1) $35,000 in the case of an individual, (2) $50,000 in the case a married couple filing a joint return, and (3) $10,000 in the case of a married individual filing separately. A couple is not treated as married if the spouses file separate returns and do not live together at any time during the year. The deduction is phased out over a $10,000 interval, so that the AGI phaseout range is (1) $25,000–$35,000 for individuals, (2) $40,000–$50,000 for married individuals filing a joint return, and (3) 0–$10,000 for married individuals filing separate returns.

Individuals are entitled to make nondeductible contributions to the extent deductible contributions are not allowed as a result of the phaseout.

In the case of an IRA to which either deductible or nondeductible contributions have been made, the investment income of the account is not taxed until withdrawn. Amounts withdrawn from an

IRA attributable to deductible IRA contributions, or earnings on deductible or nondeductible IRA contributions, are includible in income. In addition, such amounts are subject to a 10-percent additional income tax unless the withdrawal (1) is made after the IRA owner attains age 59½ or dies, (2) is made on account of the disability of the IRA owner, or (3) is one of a series of substantially equal periodic payments made not less frequently than annually over the life or life expectancy of the IRA owner (or the IRA owner and his or her beneficiary). Amounts withdrawn from an IRA that represent a return of nondeductible contributions are treated as a return of basis and, therefore, are not includible in income or subject to the 10-percent additional tax.

Effect of provision

IRA use expanded significantly when eligibility was expanded in 1982 to all persons with earnings, and contracted correspondingly in 1987 when deductibility was restricted for certain higher-income taxpayers who were covered by a pension. The percent of tax returns with wage and salary earnings that also reported a deductible IRA contribution jumped from 4.1 percent in 1981 to 14.5 percent in 1982. By 1986, 17.6 percent of returns with wage and salary earnings reported an IRA contribution, but in 1987, after tax reform, only 8.0 percent of such returns reported deductible contributions (see table 8).

TABLE 8.—USE OF DEDUCTIBLE IRA'S FROM 1981 TO 1988

[Dollars in billions]

Year	Percent of workers deducting IRA contributions	IRA deductions
1981	4.1	$4.8
1982	14.5	28.3
1983	16.4	32.1
1984	17.7	35.4
1985	18.6	38.2
1986	17.6	37.8
1987	8.0	14.1
1988	6.8	11.9

Source: Statistics of Income, 1981 to 1988.

As is the case with all income exclusions, upper income taxpayers with higher marginal tax rates receive more benefit per dollar of IRA contribution than do lower income taxpayers with lower marginal tax rates. In part for this reason, when IRAs were available to all workers the percentage of taxpayers contributing to an IRA was substantially higher among taxpayers with higher income. In 1985, for example, just 13.6 percent of taxpayers with AGI between $10,000 and $30,000 contributed to an IRA compared with 74.1 percent of taxpayers with AGI between $75,000 and $100,000 (see table 9).

The Tax Reform Act of 1986 dramatically redistributed the pattern of IRA use by eliminating deductible IRA contributions for single workers with pension coverage and AGI over $35,000 and for married couples with pension coverage and AGI over $50,000. The incidence of deductible IRA contributions among taxpayers with AGI between $75,000 and $100,000 plunged from 74.1 percent in 1985 to 8.2 percent in 1988 (see table 9). The drop in IRA use was much smaller among lower income taxpayers. Among those with AGI between $10,000 and $30,000, the incidence of deductible IRA contributions fell from 13.6 percent in 1985 to 7.1 percent in 1988.[10]

The distribution of amounts of deductible IRA contributions was similarly redistributed by the 1986 act. In 1985, taxpayers with AGI over $50,000 deducted $14.1 billion in IRA contributions, accounting for 37 percent of all IRA deductions. In 1988, taxpayers with AGI over $50,000 deducted just $2.7 billion in IRA contributions, accounting for only 22 percent of total IRA deductions.

TABLE 9.—RETURNS REPORTING DEDUCTIBLE IRA CONTRIBUTIONS, BY INCOME CLASS, 1985 AND 1988

Adjusted gross income class	Number in millions		Percent of returns with wage or self-employment income		Contributions (billions of dollars)	
	1985	1988	1985	1988 [1]	1985	1988
All classes	16.2	6.4	17.8	6.5	38.2	11.9
Under $10,000	.6	.4	2.3	1.4	1.1	.6
$10,000 to $30,000	5.1	2.7	13.6	7.1	9.7	4.6
$30,000 to $50,000	5.7	2.3	32.9	11.9	13.5	4.1
$50,000 to $75,000	3.0	.5	56.5	6.1	8.7	1.3
$75,000 to $100,000	.9	.2	74.1	8.2	2.7	.6
Over $100,000	.8	.3	76.1	11.4	2.6	.8

[1] Beginning in 1987, income limits were put on the deductibility of IRA contributions. Hence, the 1988 percentage understates utilization by eligible taxpayers, because not all wage and salary recipients are eligible to make IRA contributions.

Source: Internal Revenue Service, 1985 and 1988 Statistics of Income.

Congress established IRAs to allow workers not covered by employer pension plans to have tax-advantaged retirement saving. Nonetheless, IRA participation rates have been higher among those covered by an employer-provided pension plan than those without one, and many of those who are not covered by a pension plan do not contribute to an IRA. In 1987, for example, 15 percent of full-time private wage and salary workers with a pension contributed to an IRA while only 10 percent of those without a pension contributed (see table 10). As 51 percent of all full-time private sector workers were not covered under a pension (from table 2),

---

[10] The decline in IRA use between 1985 and 1988 among those with AGI between $10,000 and $30,000 appears to be larger than the reduction required by the change in law, since the restrictions on deductible contributions generally do not apply to taxpayers with AGI below $30,000.

IRAs only increased the fraction with some form of tax-advantaged retirement plan by 5.1 percentage points (10 percent of 51 percent).

TABLE 10.—PERCENT CONTRIBUTING TO AN IRA IN 1987 BY PENSION COVERAGE: FULL-TIME PRIVATE WAGE AND SALARY WORKERS AGED 16 OR OLDER

	Total	Men	Women
Number of full-time private wage and salary workers aged 16 or older (in thousands)	71,485	43,188	28,296
Total percent contributing to IRA	12	14	11
Covered by employer-sponsored plan	15	16	13
Basic plan only	14	15	12
Basic plan and 401(k) type	19	19	17
401(k) type only	16	17	15
Not covered	10	12	9
Don't know	3	3	3

Source: John R. Woods, "Pension Coverage Among Private Wage and Salary Workers: Preliminary Findings From the 1988 Survey of Employee Benefits," Social Security Bulletin, 52:10 (October 1989), p. 9.

EXCLUSION OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

Legislative history

Social Security benefits.—The exclusion from gross income for Social Security benefits was not initially established by statute. Prior to the Social Security Amendments of 1983, the exclusion was based on a series of administrative rulings issued by the Internal Revenue Service in 1938 and 1941 (see I.T. 3194, 1938–1 C.B. 114, I.T. 3229, 1938–2 C.B. 136, and I.T. 3447, 1941–1 C.B. 191).

A Supreme Court decision in 1937 in which Social Security benefits were characterized as "general welfare" may have been influential in resolving the issue.[11] I.T. 3194 and I.T. 3229 made lump-sum distributions nontaxable; internal IRS memoranda suggested that the payments were considered in the nature of a gift. The reasons underlying I.T. 3447 appear to include the following theories: (1) the benefits are gratuities and, thus, not subject to income tax because gifts are not taxable as income; (2) the Congress indicated its intent that the benefits not be taxable because it did not specifically make them taxable; and (3) the benefits are in the nature of public assistance for the general welfare and the Congress did not intend to tax with one hand what it pays out with the other.

Under the Social Security Amendments of 1983, a portion of the Social Security benefits paid to higher income taxpayers is included in gross income. In modifying the tax treatment of Social Security benefits in 1983, the Congress stated that Social Security benefits are in the nature of benefits received under other retirement systems, which are subject to taxation to the extent they exceed a worker's nondeductible contributions. The legislative history further indicated that taxing a portion of Social Security benefits improves tax equity by treating more equally all forms of retirement and other income that are designed to replace wages. The tax treatment of Social Security benefits is contained in section 86 of the Internal Revenue Code of 1986.

---

[11] *Helvering* v. *Davis,* 301 U.S. 619, 640 (1937).

Railroad retirement benefits.—The exclusion from gross income of benefits paid under the railroad retirement system was enacted in the Railroad Retirement Act of 1935. The rationale for the exclusion was not separately stated, but is presumed to be similar to that for excluding Social Security benefits from gross income.

A portion of the benefits payable under the railroad retirement system (generally, tier 1 benefits) is equivalent to Social Security benefits. The tax treatment of tier 1 railroad retirement benefits was modified in the Social Security Amendments of 1983 to conform generally to the tax treatment of Social Security benefits. Other railroad retirement benefits are taxable in the same manner as employer-provided retirement benefits. The Consolidated Omnibus Budget Reconciliation Act of 1985 provided that tier 1 benefits are taxable in the same manner as Social Security benefits only to the extent that Social Security benefits otherwise would be payable. Other tier 1 benefits are taxable in the same manner as all other railroad retirement benefits.

Explanation of provision

Under section 86 of the Internal Revenue Code, a portion of Social Security and tier 1 railroad retirement benefits is included in taxable income for taxpayers whose adjusted gross income ("AGI") combined with (1) interest on tax-exempt bonds and (2) 50 percent of Social Security and tier 1 railroad retirement benefits, exceeds a base amount. The base amount is $25,000 for unmarried individuals and married individuals who file a separate return and who live apart at all times during the taxable year, $32,000 for married couples filing joint returns, and zero for married persons filing separate returns who do not live apart at all times during the taxable year. The amount of benefits includible in income is the lesser of (1) 50 percent of the Social Security and tier 1 railroad retirement benefits, or (2) 50 percent of the excess of the taxpayer's combined income over the base amount.

The portion of tier 1 railroad retirement benefits potentially includible in taxable income under the above formula is the amount of benefits the taxpayer would have received if covered under Social Security. Pursuant to section 72(r) of the Internal Revenue Code of 1986, all other benefits payable under the railroad retirement system are includible in income when received to the extent they exceed employee contributions. This treatment is consistent with the tax treatment of benefits provided by retirement plans maintained by employers.

Effect of provision

A large percentage of any current Social Security recipient's benefit does not constitute a return of the recipient's contributions (which were originally made with after-tax dollars). For example, the Social Security Administration has estimated that, for individuals retiring between the years 2025 and 2030, the lifetime employee after-tax contributions will equal approximately 7 percent of their aggregate benefits.[12]

Table 11 below estimates the distribution of tax expenditures which arise from the exclusion of Social Security benefits in excess of the retiree's after-tax contribution. The table shows that the tax expenditure per return increases as the income class rises up to the $50,000 to $75,000 income class, at which point it declines slightly (except for those with incomes above $100,000). However, the tax expenditure per return is always greater for those with incomes above $40,000 than for those with incomes below $40,000. This outcome may be explained by the likelihood that higher income retirees were generally higher income individuals during their working years who were more likely to be eligible for the maximum benefit. The tendency for the tax expenditure per return to rise with income would be greater in the absence of the partial inclusion of benefits made by the Social Security Amendments of 1983, which subjected a portion of Social Security benefits to taxation for those single taxpayers with income greater than $25,000 and for those married taxpayers with income greater than $32,000.

TABLE 11.—DISTRIBUTION OF TAX EXPENDITURE: UNTAXED SOCIAL SECURITY BENEFITS, 1991

Income class (thousands)	Returns (thousands)	Amount (millions)
Below $10	(1)	(2)
$10 to $20	3,360	$641
$20 to $30	3,190	1,698
$30 to $40	3,158	2,448
$40 to $50	5,245	5,612
$50 to $75	6,062	7,186
$75 to $100	2,040	1,927
$100 to $200	1,140	1,399
$200 and over	204	376
Total	24,372	21,286

[1] Less than 500.

[2] Less than $500,000.

Source: Joint Committee on Taxation.

EXCLUSION OF EMPLOYER CONTRIBUTION FOR MEDICAL INSURANCE PREMIUMS AND MEDICAL CARE

Legislative history

In 1943, the Internal Revenue Service (IRS) ruled that employer contributions to group health insurance policies were not taxable to the employee. Employer contributions to individual health insurance policies, however, were declared to be taxable income in an IRS revenue ruling in 1953.

---

[12] CBO, "An Analysis of Alternatives for Taxing Social Security as a Private Pension," Staff Working Paper, March 1988.

Section 106 of the Internal Revenue Code, enacted in 1954, reversed the 1953 IRS ruling. As a result, employer contributions to all accident or health plans generally are excluded from taxable income. The legislative history of section 106 indicates that its purpose is to make uniform the tax treatment of employer contributions to group and individual health plans. In addition, under section 105 of the Internal Revenue Code, benefits received under an employer's accident or health plan generally are not included in the employee's income.

In the Revenue Act of 1978, Congress added section 105(h) to tax the benefits payable to highly compensated employees under a self-insured medical reimbursement plan if the plan discriminated in favor of the highly compensated employees. The Tax Reform Act of 1986 modified the health provisions by repealing section 105(h), amending section 106 to exclude employer-provided coverage (rather than contributions) under an accident or health plan, and providing that the exclusion under section 106 does not apply to highly compensated employees under an employer-provided health plan (whether or not self-insured) unless the plan does not discriminate in favor of the employer's highly compensated employees (sec. 89). By enacting these limitations on the exclusion for employer-provided health coverage, Congress stated its intent that the exclusion should not be available if a health plan favors the highly compensated employees of an employer.

Section 89 was repealed and the prior-law rules under section 105(h) were reinstated by Public Law 101-140.

Explanation of provision

Under section 106 of the Internal Revenue Code of 1986, gross income of an employee generally does not include employer-provided coverage under an accident or health plan. The exclusion under section 106 for employer-provided health coverge generally applies to coverage provided to former employees, their spouses, or dependents.

Section 105 of the Code provides that gross income does not include amounts received by an employee for personal injuries or sickness if the amounts are paid directly or indirectly to reimburse the employee for expenses incurred for medical care. However, this exclusion does not apply in the case of amounts paid to a highly compensated individual under a self-insured medical reimbursement plan which does not satisfy the nondiscrimination rules of section 105(h).

Present law permits employers to prefund medical benefits for retirees. Postretirement medical benefits may be prefunded by the employer in two basic ways: (1) through a separate account in a tax-qualified pension plan (sec. 401(h)); or (2) through a welfare benefit fund (secs. 419 and 419A). Generally, amounts contributed to section 401(h) accounts or to welfare benefit funds are not includible in the income of the plan or participants. Although amounts held in a section 401(h) account are accorded tax-favored treatment similar to assets held in a pension trust, the benefits provided under a section 401(h) account are required to be incidental to the retirement benefits provided by the plan. A welfare benefit fund also may be used to fund postretirement medical benefits. Amounts contributed to these funds are subject to certain deduction limitations (secs. 419 and 419A). Additionally, the fund is subject to income tax relating to any set aside to provide postretirement medical benefits.

Effect of provision

Historically, the tax law has included incentives for employers to provide certain benefits to their employees, such as health coverage. The exclusion for employer-provided health coverage provides an incentive for compensation to be furnished in the form of health coverage, rather than in cash subject to current taxation.

For example, an employer designing a compensation package for an employee would be indifferent between paying the employee one dollar in cash and purchasing one dollar's worth of health insurance for the employee.[13] If the employee's marginal tax rate (including Federal and State income taxes and payroll taxes) is t, then the value of one dollar of cash compensation is only $(1-t)$ dollars. Thus, the employee would prefer to be compensated with health insurance as long as the value of a dollar of health insurance is worth at least $(1-t)$ dollars to the employee. As is the case with any deduction or exclusion, employees subject to tax at the highest marginal tax rate have the greatest incentive to receive compensation in a form other than currently taxable amounts.

Table 12 presents data summarizing the growth over four decades of employer contributions to group health plans.[14] Contributions to group health plans, second only to qualified pension plans in dollar amount, more than doubled in the 5 year period 1980-1985, and reached $115.3 billion in 1987. This represents growth of more than 50 percent in real terms over the 1980-87 period.

Table 12 also shows how group health benefits have grown compared to total wages and salaries. Group health benefits grew from 0.8 percent of wages in 1955 to 5.1 percent of wages in 1987.

TABLE 12.—EMPLOYER CONTRIBUTIONS FOR GROUP HEALTH INSURANCE, 1955–87

[Dollar amounts in billions]

	1955	1960	1965	1970	1975	1980	1985	1987
Amount [1]	$1.7	$3.4	$5.9	$12.1	$24.0	$49.8	$100.8	$115.3
Amount in 1987 dollars	7.2	13.0	21.3	35.4	50.7	68.7	106.4	115.3
Percent of wages and salaries	.8	1.2	1.6	2.2	3.0	3.7	5.1	5.1

[1] Amounts are based on Department of Commerce reported data and include employer contributions for short- and long-term disability insurance covering private employees and their dependents.

---

[13] To the extent the employer bears a portion of the payroll tax, the employer may actually prefer to provide compensation through health insurance (which is not subject to payroll tax).

[14] The data includes employer contributions for disability insurance which accounts for roughly 10 percent of total contributions.

CAFETERIA PLANS

Legislative history

Under present law, compensation generally is includible in gross income when actually or constructively received. An amount is constructively received by an individual if it is made available to the individual or the individual has an election to receive such amount. An exception to the general principle of constructive receipt applies if an employee may elect between cash and certain employer-provided nontaxable benefits (e.g., coverage under a health plan) under a cafeteria plan described in section 125 of the Internal Revenue Code.

Section 125 was added to the Tax Code by the Revenue Act of 1978 (P.L. 95-600). Prior to the enactment of section 125, section 2006 of the Employee Retirement Income Security Act of 1974 (ERISA) provided that an employer contribution made before January 1, 1977, to a cafeteria plan in existence on June 27, 1974, was required to be included in an employee's gross income only to the extent that the employee actually elected taxable benefits. In the case of a plan not in existence on June 27, 1974, the employer contribution was required to be included in income to the extent the employee could have elected taxable benefits. Under the Tax Reform Act of 1976, these rules applied with respect to employer contributions made before January 1, 1978. The Foreign Earned Income Act of 1978 (P.L. 95-615) extended these rules until the effective date of the Revenue Act of 1978.

The ERISA provision and the extensions that followed were intended to be temporary and to allow further Congressional study of the tax treatment of cafeteria plans. With the enactment of section 125, Congress provided permanent rules with respect to plans that offer an election between taxable and nontaxable benefits. These rules include a requirement that the plan be in writing. In addition, the plan must meet certain nondiscrimination rules relating both to eligibility and to the contributions and benefits under the plan.

Several changes to section 125 were made by the Deficit Reduction Act of 1984 (P.L. 98-369) (DEFRA). Under DEFRA, the types of employer-provided benefits (both taxable and nontaxable) that could be provided through a cafeteria plan were clarified. DEFRA also contained detailed transition relief concerning the operation of cafeteria plans with respect to certain benefits. The clarification and the transition rules resulted from Congressional concern that widespread confusion existed among employers regarding the operation of the cafeteria plan rules.

DEFRA also added the present law 25-percent concentration test. The concentration test was adopted because Congress believed that the prior-law nondiscrimination rules were inadequate to prevent a significant amount of cafeteria plan benefits from being provided to key employees. Finally, annual reporting to the IRS by employers concerning cafeteria plans was also required by DEFRA in order to obtain sufficient information relating to the use of cafeteria plans.

The Tax Reform Act of 1986 (the 1986 Act) modified the rules relating to cafeteria plans in several respects. Certain of these modifications to cafeteria plans contained in the 1986 Act were related to the enactment of former Code section 89 which imposed nondiscrimination rules on certain employee benefit plans.

Under the legislation to increase the public debt limit (P.L. 101-140), section 89 was repealed and the nondiscrimination rules relating to cafeteria plans under section 125 were returned to their status prior to its enactment.

Explanation of provisions

A participant in a cafeteria plan meeting the requirements of section 125 is not treated as having received taxable income solely because the participant had the opportunity to elect to receive cash or certain nontaxable benefits. In order to meet the requirements of section 125, the plan must be in writing, must include only employees (including former employees) as participants, and must satisfy certain nondiscrimination requirements.

In general, a nontaxable benefit may be provided through a cafeteria plan if the benefit is excludable from the participant's gross income by reason of a specific provision of the Code. Thus, employer-provided health coverage, group-term life insurance coverage (whether or not subject to tax by reason of being in excess of the dollar limit on the exclusion for such insurance), and benefits under dependent care assistance programs may be provided through a cafeteria plan. However, a cafeteria plan may not provide qualified scholarships or tuition reduction (sec. 117), educational assistance (sec. 127), or miscellaneous employer-provided fringe benefits (sec. 132). In addition, a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)).

The exception to the constructive receipt principle provided for cafeteria plans does not apply to highly compensated individuals if the plan discriminates in favor of such individuals as to eligibility to participate or as to contributions or benefits under the plan. A plan is not discriminatory as to eligibility if the plan benefits a nondiscriminatory classification of employees and requires no more than 3 years of employment as a condition of participation. Special rules apply for determining whether a plan that provides health coverage is discriminatory with respect to contributions and benefits. In addition, a plan is not discriminatory if the plan is maintained under a collective bargaining agreement.

For purposes of these nondiscrimination requirements, a highly compensated individual is an officer, a shareholder owning more than 5 percent of the employer, a highly compensated individual (determined under the facts and circumstances of the case), or a spouse or dependent of the above individuals.

In the case of a key employee, the exception to the constructive receipt principle does not apply if the nontaxable benefits provided under the plan to such employees exceed 25 percent of the aggregate of such benefits provided for all employees under the plan. A key employee is defined in the special top-heavy rules applicable to qualified pension plans (sec. 416).

An employer that maintains a cafeteria plan is required to file an annual return relating to such plan.

Effects of provisions

The optimal compensation of employees (in a tax planning sense) would require that employers and employees arrive at the compensation package providing the largest after-tax benefit to the employee at minimum after-tax cost to the employer.[15] That is, the potential taxation of compensation provided to employees would be considered in designing the most preferred compensation package as would the deductibility of compensation provided by the employer. If only income taxes were considered, employers would be indifferent between the payment of $1 in salary or wages and the payment of $1 in fringe benefits to an employee, because both types of compensation are fully deductible. In both cases, the after-tax cost to the employer of one dollar in compensation is ($\$1-t_c$) where t_c is the marginal tax rate of the employer.[16] When the employer payments for FICA and FUTA taxes are considered, the employer might actually find it less costly (in terms of after-tax dollars) to compensate an employee with a dollar's worth of fringe benefit not subject to FICA and FUTA taxes rather a dollar of wage or salary payments that have these taxes assessed on them.[17]

The employee, however, would prefer to be compensated in the form that provides the highest marginal after-tax value. An additional dollar of salary or wage paid to the employee will be valued on an after-tax basis at $(1-t_e)$, where t_e is the marginal tax rate of the employee (and includes all taxes on wage or salary income). That is, the employee receives $(1-t_e)$ dollars of after-tax compensation for one dollar of wage or salary income. If one dollar in a fringe benefit provided by the employer is excludable from the employee's income, the employee pays no tax on receipt of the benefit. Consequently, the employee receives a dollar's worth of compensation via this fringe benefit. This differential treatment of salary or wage payments and excludable fringe benefits implies that compensation packages designed to minimize the joint tax liability of employers and employees could include substantial amounts of excludable fringe benefits.

An employee may not view one dollar of fringe benefits as superior to $(1-t_e)$ dollars in cash compensation. For example, an employee with no dependents may place little value on employer-provided life insurance. The tax-efficient compensation of employees would require that employees be provided excludable fringe benefits in lieu of salary or wage payments when the employee values a dollar of excludable fringe benefit more than $(1-t_e)$.[18] However, since tastes of employees for fringe benefits (the value employees put on a dollar's worth of a particular fringe benefit) and the marginal tax rates of employees will differ (meaning that t_e is not a constant for all employees), there will often be no consensus among employees as to which types of excludable fringe benefits are worth more than $(1-t_e)$ per dollar to the work force. Given these differences, efficient compensation planning would require that employers offer compensation packages that are tailored to employees' individual situations.[19] This implies that cafeteria plans permitting employees some discretion as to the provided benefits will dominate benefit plans where all employees of the firm receive the identical benefit package.

---

[15] This analysis follows that contained in Myron Scholes and Mark Wolfson, "Taxes and Business Strategy: A Global Approach," see especially chapter 10.

[16] Note that t_c can range from 0 (tax-exempt employers) to the maximum statutory marginal tax rate (34 percent for corporations), ignoring State and local income taxes.

[17] A more precise statement is that the employer is indifferent between providing $1 salary or wages and $(1+t_f)$ dollars in excludable fringe benefits, where t_f is the marginal tax rate for FICA and FUTA imposed on wage payments (this payroll tax is deductible by the employer).

[18] As mentioned earlier, this understates the trade-off, since no account is taken of the employer portion of FICA and FUTA taxes. The more precise statement would be that the employee is more efficiently compensated using excludable fringe benefits when the employee values $(1+t_f)$ dollars of excludable fringe benefits more than $(1-t_e)$.

Evidence of the desirability of cafeteria plans as part of a compensation scheme that minimizes the joint tax liability of the employer and employee is available from several sources. Surveys by employee benefits researchers indicate cafeteria plans are a growing part of compensation plans, particularly for larger employers. For example, the Bureau of Labor Statistics estimates that for 1988, 13 percent of employees at large and medium sized firms were eligible for flexible benefits and/or reimbursement accounts (the terms used for cafeteria plans in this survey). Preliminary data indicate that for 1989, the percentage eligible had grown to 23 percent for the same group of employees.[20] These figures indicate that cafeteria plans are becoming more common particularly among professional and administrative workers. Additional supporting evidence comes from the estimates of the cafeteria plan tax expenditure provided by the Joint Committee on Taxation. These estimates have more than doubled in the last 5 years, growing from $1.0 billion in 1987 to $2.6 billion in 1992.

Cafeteria plan benefits are generally funded by either employee contributions alone or by a combination of employee and employer contributions. Current practice is that approximately half of the firms offering cafeteria plans use each type of funding mechanism. Typical benefits provided through cafeteria plans include (but are not limited to): choices among health plans, flexible spending accounts for health care or for dependent care, and life and disability insurance choices.

The exclusion from gross income for cafeteria plan benefits, like any income exclusion, can lead to inequities in the tax system. Employees with the same economic income from compensation can have taxable incomes that are substantially different due to the form in which compensation is received. The exclusion for cafeteria plan benefits may also be used in some cases to avoid the 7.5 percent floor on deductible medical expenses. There is some evidence that cafeteria plans may undermine sound health policy. The use of cafeteria plans reduces the after-tax cost of health care to employees utilizing these plans, which could cause these employees to purchase an unnecessarily large amount of health care services. This over-utilization could lead to increases in health care costs.[21]

---

[19] For example, the employee with no dependents and no bequest motive may put little value on employer-provided life insurance. This employee would not want employer provided life insurance to be part of the offered compensation package. However, a different employee might have a strong bequest motive and desire that employer-provided life insurance be part of the offered compensation package.

[20] Sources for these data are "Employee Benefits in Medium and Large Firms, 1988", Bulletin 2336, Bureau of Labor Statistics, Department of Labor, August 1989, and preliminary updates of similar material for 1989.

[21] See, for instance, "A Study of Cafeteria Plans and Flexible Spending Accounts," U.S. Department of Health and Human Services, July 1985.

In the absence of any constraints, cafeteria plans might be used to provide very large sums of tax-favored fringe benefits to highly compensated employees without providing similar choices to lower paid workers. To address this concern, the Code restricts the ability of firms to target cafeteria plan treatment to highly paid workers through specific nondiscrimination rules. These rules recognize the tradeoff between tax-efficient compensation planning and the desire of Congress to spread the use of tax-favored compensation through fringe benefits throughout the entire work force.

HEALTH CARE CONTINUATION RULES

Legislative history

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added sections 106(b), 162(i)(2), and 162(k) to the Internal Revenue Code under which certain group health plans are required to offer health coverage to certain former employees, as well as spouses and dependents of certain employees or former employees. Parallel requirements were added to title I of the Employee Retirement Income Security Act of 1974 and the Public Health Services Act. Under COBRA, in the case of a failure to satisfy the health care continuation rules, the employer was denied a deduction for contributions to its group health plans and highly compensated employees were required to include in taxable income the employer-provided value of the coverage received under such plans. Technical amendments were made to these health care continuation requirements in the Tax Reform Act of 1986.

The Technical and Miscellaneous Revenue Act of 1988 made several changes to the health care continuation rules. Sections 106(b), 162(i)(2) and 162(k) were repealed and replaced by section 4980B, which now contains the health care continuation rules. In the case of a failure to satisfy the health care continuation requirements, section 4980B imposes an excise tax on the employer or other responsible party in lieu of the loss of deductibility formerly found in section 162(i)(2) and the loss of the health coverage exclusion formerly found in section 106(b). Further technical amendments to the health care continuation rules, were made by the Omnibus Budget Reconciliation Act of 1989 and the Omnibus Budget Reconciliation Act of 1990.

Explanation of provision

Certain employer-provided accident or health plans are required to satisfy health care continuation rules (sec. 4980B). In general, these rules require that an employer provide qualified beneficiaries with the opportunity to participate for a specified period in the employer's health plan after the occurrence of a qualifying event that otherwise would have terminated such participation.

The qualifying events that may trigger rights to continuation coverage are (1) the death of the employee; (2) the voluntary or involuntary termination of the employee's employment (other than by reason of gross misconduct); (3) a reduction of the employee's hours; (4) the divorce or legal separation of the employee; (5) the employee becoming entitled to benefits under Medicare; and (6) a dependent child of the employee ceasing to be a dependent under the employer's plan. The maximum period of continuation coverage that may be elected is 36 months, except in the case of termination of employment or reduction of hours for which the maximum period is 18 months. The 18-month period is extended to 29 months in certain cases involving the disability of the qualified beneficiary. Certain events, such as the failure by the qualified beneficiary to pay the required premium, may trigger an earlier cessation of the continuation coverage.

A qualified beneficiary has a prescribed period of time after a qualifying event in which to elect continuation coverage. This period does not commence until the employee receives notice from the plan administrator of the right to continuation coverage.

If a plan subject to the health care continuation rules fails to satisfy the rules, an excise tax is imposed on the employer. In certain circumstances, persons other than the employer may be liable for the excise tax.

EXCLUSION OF MEDICARE BENEFITS

Legislative history

The exclusion from income of Medicare benefits has never been expressly established by statute. A 1970 IRS ruling, Rev. Rul. 70–341, 1970–2 C.B. 31, provided that the benefits under Part A of Medicare are not includible in gross income because they are in the nature of disbursements made in furtherance of the social welfare objectives of the Federal Government. The Internal Revenue Service relied on a similar ruling, Rev. Rul. 70–217, 1970–1 C.B. 13, with respect to the excludability of old age and survivors insurance benefits and disability insurance benefits (OASDI) in reaching this conclusion. (For background on the exclusion of OASDI benefits, see above.)

Rev. Rul. 70–341 also held that benefits under Part B of Medicare are excludable under Code section 104 as amounts received through accident and health insurance (though the subsidized portion of Part B also may be excluded under the same theory applicable to the exclusion of Part A benefits).

Explanation of provision

Benefits under Part A and Part B of Medicare are excludable from the gross income of the recipient. In general, Part A pays for certain in-patient hospital care, skilled nursing facility care, home health care, and hospice care for eligible individuals (generally the elderly and the disabled). Part B covers certain doctor's services and other medical services for elderly or disabled individuals who elect to pay the required premium.

DEDUCTIBILITY OF MEDICAL EXPENSES

Legislative history

An itemized deduction for unreimbursed medical expenses above a specified floor has been allowed since 1942. From 1954 through 1982, the floor under the medical expense deduction was 3 percent of the taxpayer's adjusted gross income ("AGI"); a separate floor of 1 percent of AGI applied to expenditures for medicine and drugs.

In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the overall floor was increased to 5 percent of AGI effective beginning with the 1983 calendar year, and was applied to the total of all eligible medical expenses, including prescription drugs and insulin. TEFRA made nonprescription drugs ineligible for the deduction, and eliminated the separate floor for drug costs.

The Tax Reform Act of 1986 increased the floor under the medical expense deduction to 7.5 percent of AGI, beginning in 1987.

Explanation of provision

Individuals who itemize deductions may deduct amounts paid during the taxable year, if not reimbursed by insurance or otherwise, for medical care of the taxpayer and of the taxpayer's spouse and dependents, to the extent that the total of such expenses exceeds 7.5 percent of AGI (sec. 213).

Medical care expenses eligible for the deduction include amounts paid by the taxpayer for (1) health insurance (including after-tax employee contributions to employer health plans); (2) diagnosis, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (3) transportation primarily for and essential to medical care; and (4) lodging away from home primarily for and essential to medical care, up to $50 per night. The costs of prescription drugs and insulin also are eligible for the medical care expense deduction.

Expenses paid for the general improvement of health, such as fees for exercise programs, are not eligible for the deduction unless prescribed by a physician to treat a specific illness.

A deduction generally is not allowed for cosmetic surgery or similar procedures that do not meaningfully promote the proper function of the body or treat disease. However, such expenses are deductible if the cosmetic procedure is necessary to correct a deformity arising from a congenital abnormality, an injury resulting from an accident, or disfiguring disease.

Medical expenses are not subject to the general limitation on itemized deductions applicable to taxpayers with adjusted gross incomes over $100,000 (adjusted for inflation), which was enacted as part of the Omnibus Budget Reconciliation Act of 1990.

Effect of provision

Personal expenses such as medical expenses generally are not deductible from gross income because they do not constitute a cost incurred while earning income. However, the Code allows taxpayers to claim an itemized deduction if unreimbursed medical expenses absorb a substantial portion of income and, thus, adversely affect the taxpayer's ability to pay taxes. In order to limit the deduction to extraordinary medical expenses (e.g., uninsured surgery), the tax law provides that medical expenses are deductible only to the extent that they exceed a specified percentage (now 7.5 percent) of the taxpayer's AGI.

In comparison to the 7.5-percent floor, medical expenditures comprised 11.1 percent of United States gross national product of the United States in 1987. However, such a figure overstates the experience of families with respect to their unreimbursed payments because of government purchases of medical services (e.g., Medicare and Medicaid) and employer provided medical insurance. Table 13 reports the average unreimbursed, out-of-pocket medical expenditures of households. Since 1980, such expenditures have always exceeded 4 percent of household expenditures.

Table 14 shows the effect of the increases in the floor on medical deductions from 3 percent, to 5 percent, and most recently to 7.5 percent on taxpayers claiming such deductions. In the absence of an increase in the floor on the deduction of medical expenses, one would have expected the number of taxpayers claiming the deduction and the average deduction claimed to have increased because of general price inflation and because inflation of medical costs has exceeded inflation of the general price level. However, increasing the floor should reduce the number of taxpayers claiming the deduction while increasing the average magnitude of deductible expenses claimed if many taxpayers with relatively modest expenses no longer qualify while taxpayers with large expenses continue to qualify. The average deduction claimed has increased substantially, from $769 in 1980 to $3,750 in 1988. Both the increase in the floor to 5 percent and the subsequent increase to 7.5 percent substantially reduced the number of taxpayers claiming deductions for medical expenses from 19.5 million in 1980, to 9.7 million in 1983, to 4.8 million in 1988. Changes in the standard deduction and personal exemptions would also be expected to affect the number of taxpayers claiming itemized deductions and thereby affect the number of taxpayers reporting deductible medical expenditures.

TABLE 13.—AVERAGE UNREIMBURSED EXPENDITURES ON HEALTH CARE BY CONSUMER UNITS 1980–87

Year	Health Care Expenditures	
	Amount	Percentage of total expenditure
1980 [1]	$730	4.4
1981 [1]	762	4.3
1982 [1]	833	4.6
1983 [1]	899	4.6
1984 [2]	1,049	4.8
1985 [2]	1,108	4.7
1986 [2]	1,135	4.8
1987 [2]	1,135	4.6

[1] Urban consumer units only; excludes expenditures on nonprescription drugs.

[2] All consumer units; includes expenditures on nonprescription drugs.

Source: U.S. Bureau of Labor Statistics, "Consumer Expenditure Survey."

TABLE 14.—TAX RETURNS CLAIMING DEDUCTIBLE MEDICAL AND DENTAL EXPENSES

Year	Total returns filed number (in millions)	Returns claiming medical and dental expenses		
		Number of returns (in millions)	Total expenses claimed (in billions)	Deductible expenses
1980	93.2	19.5	$25.3	15.0
1981	95.4	21.4	30.2	17.9
1982	95.3	22.0	38.0	21.7
1983	96.3	9.7	35.6	18.1
1984	99.4	10.7	34.7	21.5
1985	101.7	10.8	37.1	22.9
1986	103.0	10.5	39.2	25.1
1987	107.0	5.4	27.9	17.2
1988	109.7	4.8	28.3	18.0

Source: Internal Revenue Service, "Statistics of Income."

As with other itemized deductions, taxpayers in higher tax-rate brackets receive more of a benefit from each dollar of deductible medical expense (exceeding the 7.5 percent AGI floor) than do taxpayers in lower tax-rate brackets. However, because the floor automatically rises with a taxpayer's income, higher-income taxpayers are able to deduct a smaller amount (if any) of medical expenses above their floor than are lower-income taxpayers incurring the same aggregate amount of medical expenses.

In 1991, it is estimated that, of the tax returns on which the deduction is claimed, 74 percent represent taxpayers below the $50,000 income class. As table 15 shows, these returns (below the $50,000 income class) will obtain 47 percent of the tax benefits provided by the medical expense deduction.

TABLE 15.—DISTRIBUTION OF TAX EXPENDITURE: MEDICAL DEDUCTION, 1991

Income class (thousands)	Returns (thousands)	Amount (millions)	Average
0 to $10	21	$2	$95
$10 to $20	466	132	283
$20 to $30	1,080	409	379
$30 to $40	1,070	404	378
$40 to $50	746	304	408
$50 to $75	817	613	750
$75 to $100	233	280	1,202
$100 to $200	124	371	2,992
$200 and over	22	143	6,500
Total	4,580	$2,657	$580

Source: Joint Committee on Taxation.

EARNED INCOME TAX CREDIT

Legislative history

The earned income tax credit (Code sec. 32) was enacted in 1975 as a means of targeting tax relief to working low-income taxpayers with children, providing relief from the Social Security payroll tax for these taxpayers, and improving incentives to work.

As originally enacted, the credit equalled 10 percent of the first $4,000 of earned income (i.e., a maximum credit of $400). The credit began to be phased out for adjusted gross income (AGI) (or, if greater, earned income) above $4,000, and was entirely phased out for taxpayers with AGI of $8,000. For 1979 through 1984, the maximum credit was increased to $500 (10 percent of the first $5,000 of earned income). Also, the income level at which the phaseout began was raised to $6,000, with a complete phaseout not occurring until an income level of $10,000. For 1985 and 1986, the maximum credit was increased to $550 (11 percent of the first $5,000 of earned income) and the credit was phased out beginning at $6,000 of income and ending at $11,000. Prior to 1987, the dollar amount of the earned income tax credit (EITC) was not indexed for inflation.

Under the Tax Reform Act of 1986, the maximum credit was increased to $800 (14 percent of the first $5,714 of earned income), beginning in 1987. The maximum credit was reduced by 10 cents for each dollar of AGI (or, if greater, earned income) in excess of $9,000 ($6,500 in 1987). These amounts are before adjustment for inflation.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) substantially increased the maximum amount of the basic credit and added an adjustment to reflect family size. OBRA 1990 also created two additional credits as part of the earned income tax credit. These additional components of the EITC are the supplemental young child credit and the supplemental health insurance credit. Both of these supplemental credits use the same base as the basic EITC.

For 1991, the basic EITC rate is 16.7 percent for taxpayers with one qualifying child and 17.3 percent for taxpayers with more than one qualifying child. The credit base of earned income was not changed by OBRA 1990. For 1991, the maximum basic EITC is $1,192 (16.7 percent of $7,140) for taxpayers with one qualifying child and $1,235 (17.3 percent of $7,140) for taxpayers with more than one qualifying child. For 1991, the EITC is phased out for taxpayers with AGI (or, if greater, earned income) above $11,250 at a rate of 11.93 cents for each dollar of AGI over the threshold (12.36 cents for families with 2 or more children). The basic EITC is completely phased out for AGI above $21,242 in 1991. Under OBRA 1990, the credit percentages and the phaseout percentages are scheduled to increase over the 1991 to 1994 period (as shown in Table 16). The income thresholds will be adjusted for inflation.

OBRA 1990 also modified the group of taxpayers eligible for the EITC. Under prior law, taxpayers were required to file a joint return or file as a head of household in order to be eligible for the EITC. OBRA 1990 generally broadened the set of eligible taxpayers by changing the eligibility rules to require that a taxpayer have a qualifying child in order to claim the EITC. A qualifying child generally is any child who resides with the taxpayer for more than half the taxable year. However, a person cannot be a qualifying child for more than one taxpayer.

TABLE 16.—EARNED INCOME CREDIT PARAMETERS, 1975–95 [1]

Calendar year	Credit rate (percent) [2]	Minimum income for maximum credit	Maximum credit	Phaseout rate (percent)	Phaseout range	
					Beginning income	Ending income
1975–78	10	$4,000	$400	10.00	$4,000	$8,000
1979–80	10	5,000	500	12.50	6,000	10,000
1981–84	10	5,000	500	12.50	6,000	10,000
1985–86	11	5,000	550	12.22	6,500	11,000
1987	14	6,080	851	10.00	6,920	15,432
1988	14	6,240	874	10.00	9,840	18,576
1989	14	6,500	910	10.00	10,240	19,340
1990	14	6,810	953	10.00	10,730	20,264
1991	16.7	7,140	1,192	11.93	11,250	21,242
1992 [3]	17.6	7,570	1,332	12.57	11,920	22,517
1993 [3]	18.5	7,840	1,450	13.21	12,350	23,327
1994 [3]	23	8,120	1,868	16.43	12,790	24,159
1995 [3]	23	8,410	1,934	16.43	13,250	25,021

[1] For years after 1990, the parameters do not include the supplemental young child credit and the supplemental health insurance credit.

[2] Assumes one qualifying child. Both credit rates and phaseout rates are higher for taxpayers with two or more qualifying children: In 1991: 2 children=17.3 percent credit, 12.36 percent phaseout. In 1992: 2 children=18.4 percent credit, 13.14 percent phaseout. In 1993: 2 children=19.5 percent credit, 13.93 percent phaseout. In 1994 and thereafter: 2 children=25 percent credit, 17.86 percent phaseout.

[3] Projection.

Source: Joint Committee on Taxation.

Table 17 illustrates the EITC parameters in constant dollars. For example, the maximum credit of $400 in 1975 is equivalent to $918 in 1990 dollars. Adjusting this credit for the increase in Social Security taxes yields an equivalent 1977 maximum credit (in 1990 dollars) of $1,200. The income level at which the credit ends is greater in 1990 than in 1975 even after adjusting for inflation.

TABLE 17.—EARNED INCOME CREDIT AMOUNTS IN 1990 CONSTANT DOLLARS, SELECTED YEARS 1975–94

	Minimum income for maximum credit	Maximum credit	Maximum credit adjusted [1]	Phaseout range	
				Beginning income	Ending income
1975	$9,181	$918	$1,200	$9,181	$18,362
1978	7,644	764	966	7,644	15,289
1980	7,847	785	980	9,416	15,693
1982	6,747	675	771	8,096	13,494
1985	5,994	659	715	7,793	13,188

TABLE 17.—EARNED INCOME CREDIT AMOUNTS IN 1990 CONSTANT DOLLARS, SELECTED YEARS 1975–94—Continued

	Minimum income for maximum credit	Maximum credit	Maximum credit adjusted [1]	Phaseout range	
				Beginning income	Ending income
1988	6,815	953	971	10,730	20,256
1990	6,810	953	953	10,730	20,264
1991	6,777	1,131	1,131	10,678	20,162
1992	6,935	1,220	1,220	10,920	20,627
1993	6,931	1,282	1,282	10,918	10,621
1994	6,930	1,651	1,651	11,309	20,620

[1] Maximum credit adjusted is the maximum credit from the previous column adjusted for the increase in the Social Security tax.

Note: Constant dollars obtained by using the CPI–X1 price index.

Source: Ways and Means Committee Staff.

Explanation of provision

Eligibility.—The EITC is available to taxpayers with a "qualifying child". In order to be a qualifying child, an individual must satisfy a relationship test, a residency test, and an age test. The relationship test requires that the individual be a child, stepchild, a descendent of a child, or a foster or adopted child of the taxpayer. The residency test requires that the individual have the same place of abode as the taxpayer for more than half the taxable year. This household must be located in the United States. The age test requires that the individual be under 19 (24 for a full-time student) or be permanently and totally disabled.

To claim the EITC, a taxpayer must complete a separate schedule and attach it to his or her return. In addition, to claim the EITC, the taxpayer must supply the taxpayer identification number (Social Security number) for each qualifying child over the age of 1 year.

Benefits.—Eligible low-income workers may claim a refundable earned income tax credit (EITC) of up to 16.7 percent (17.3 percent for taxpayers with more than 1 qualifying child) of the first $7,140 of earned income for 1991. The maximum amount of credit for 1991 is $1,192 ($1,235 for taxpayers with more than 1 qualifying child), and this maximum is reduced by 11.93 percent (12.36 percent for taxpayers with more than 1 qualifying child) of earned income (or AGI, if greater) in excess of $11,250. The EITC is totally phased out for workers with earned income over $21,242. Earned income consists of wages, salaries, other employee compensation, and net self-employment income.

There are two additional credits that are part of the EITC. A supplemental young child credit is available for taxpayers with qualifying children under the age of one year old. This supplemental young child credit rate is 5 percent and the phaseout rate is 3.57 percent. It is computed on the same base as the ordinary EITC (the maximum credit for 1991 is $357). A supplemental credit for health insurance costs is also provided for taxpayers who purchase health insurance policies that include coverage for qualifying children. This supplemental health insurance credit rate is 6 percent and the phaseout rate is 4.285 percent. It is computed on the same base as the ordinary EITC (the maximum credit for 1991 is $428). The maximum credit available to a taxpayer is limited to the amount paid for the health insurance coverage (in after-tax dollars).

Unlike most tax credits, the earned income credit is refundable; i.e., if the amount of the credit exceeds the taxpayer's Federal income tax liability, the excess is payable to the taxpayer. Also, under an advance payment system, eligible taxpayers may elect to receive the benefit of the credit in their paychecks, rather than waiting to claim a refund on their return filed by April 15 of the following year. Where the individual does not claim the credit, but the IRS can determine from the return that the individual may be eligible, the IRS will contact the taxpayer to encourage eligible taxpayers to claim the EITC.

Interaction with means-tested programs.—The treatment of the earned income credit for purposes of AFDC and food stamp benefit computations has varied since inception of the credit. When enacted in 1975, the credit was not considered income in determining AFDC and food stamp benefits, and the credit could not be received on an advance basis. From January 1979 through September 1981, the credit was treated as earned income when actually received. Receipt of the credit on an advance basis was authorized in July 1979.

From October 1981 to September 1984, the amount of the credit was treated as earned income and was imputed to the family even though it may not have been received as an advance payment. Pursuant to the Deficit Reduction Act of 1984, the credit was treated as earned income only when received, either as an advance payment or as a refund after conclusion of the year.

Under the Family Support Act of 1988, States generally were required to disregard any advance payment or refund of the earned income credit when calculating AFDC or benefits. However, the credit was counted against the gross income eligibility standard (185 percent of the State need standard) for both applicants and recipients.

OBRA 1990 specified that, effective January 1, 1991, the EITC was not to be taken into account as income (for the month in which the payment is received or any following month) or as a resource (for the month in which the payment is received or the following month) for determining the eligibility or amount of benefit for AFDC, Medicaid, SSI, food stamps, or low-income housing programs.[22]

Effect of provision

For calendar year 1991, it is estimated that earned income tax credits totaled $8.3 billion, of which $7.5 billion represent Treasury payments in excess of current year tax liability and $0.8 billion will be offset against the individual's tax liability (see table 18). It is estimated that some 11.4 million families will receive the credit, which is expected to average $724 per family. Only approximately 10,000 families received advance payments, totaling about $2.0 million in 1987.

---

[22] Note that the interaction of the EITC with some of these means-tested programs was addressed in prior law.

Table 18 shows the total amount of earned income credits received for each of the calendar years since the inception of the program, the number of recipient families, the amount of the credits received as Treasury payments, and the average amount of the credit received per family.

TABLE 18.—TOTAL AMOUNT OF EARNED INCOME CREDIT, NUMBER OF FAMILIES RECEIVING CREDIT, AND BUDGET OUTLAYS, 1975–92

Calendar year to which credit applies	Total amount of credit (millions)	Number of families who received credit (thousands)	"Refunded" portion of credit [1] (millions)	Average credit per family
1975	$1,250	6,215	$900	$201
1976	1,295	6,473	890	200
1977	1,127	5,627	880	200
1978	1,048	5,192	801	202
1979	2,052	7,135	1,395	288
1980	1,986	6,954	1,370	286
1981	1,912	6,717	1,278	285
1982	1,775	6,395	1,222	278
1983	1,795	7,368	1,289	224
1984	1,638	6,376	1,162	257
1985	2,088	7,432	1,499	281
1986	2,009	7,156	1,479	281
1987	3,931	8,738	2,930	450
1988	5,940	11,148	4,257	533
1989 [2]	6,632	11,231	5,902	591
1990 [3]	7,030	11,288	6,257	623
1991 [3]	8,291	11,450	7,474	724
1992 [3]	9,423	11,513	8,530	818

[1] This is the portion of the credit that exceeds tax liability, and it is treated as a budget outlay. The rest of the credit is classified as a "tax expenditure." All these credits were paid in the following year until 1979, when advance payments of the credit were permitted by addition to the worker's paycheck.

[2] Preliminary.

[3] Projection. For 1991 and 1992, total amounts of credit includes the supplemental young child tax credits.

Source: Joint Committee on Taxation.

The income limitations for the earned income credit are indexed for inflation. Table 19 shows the amount of credit available at various income levels for 1988 through 1992 (the projection for 1992 is based on Congressional Budget Office estimates of inflation).

TABLE 19.—EARNED INCOME CREDIT SCHEDULE, 1988–92

Adjusted gross income [1]	Earned income credit				
	1988	1989	1990	1991 [2]	1992 [2]
$1,000	$140	$140	$140	$167	$176
2,000	280	280	280	334	352
3,000	420	420	420	501	528
4,000	560	560	560	668	704
5,000	700	700	700	835	880
6,250	[3] 875	875	875	1,044	1,100
6,500	875	[3] 910	910	1,086	1,144
6,810	875	910	[3] 953	1,137	1,199
7,140	875	910	953	[3] 1,192	1,257
7,570	875	910	953	1,192	[3] 1,332
8,000	875	910	953	1,192	1,332
9,000	875	910	953	1,192	1,332
9,840	875	910	953	1,192	1,332
10,240	751	910	953	1,192	1,332
10,730	702	861	953	1,192	1,332
11,250	650	809	901	1,192	1,332
11,920	583	742	834	1,112	1,332
13,000	475	634	726	983	1,196
14,000	375	534	626	864	1,071
15,000	275	434	526	745	945
16,000	175	334	426	625	819
17,000	75	234	326	506	693
18,576	[4] 0	76	168	318	495
19,360	0	[4] 0	90	224	397
20,270	0	0	[4] 0	116	282
21,240	0	0	0	[4] 0	160
22,520	0	0	0	0	[4] 0

[1] Adjusted gross income is assumed equal to earned income (i.e., wages, salaries, tips, nontaxable compensation, and self-employment income) for this illustration.

[2] In 1991 and thereafter, the table reflects the EITC for a family with one qualifying child. A family with two or more qualifying children would receive a larger credit.

[3] Maximum earned income credit.

[4] Earned income credit fully phased out.

Source: Joint Committee on Taxation.

The distribution of tax expenditures for the earned income credit as estimated for 1991 taxpayers is shown in table 20 for all tax returns with a breakdown by filing status. The data indicate that nearly three-fifths of the taxpayers claiming the EITC are single filers or heads of household, with the rest of the claimants being joint return filers.

TABLE 20.—DISTRIBUTION OF TAX EXPENDITURE: EARNED INCOME CREDIT, 1991

Income class (thousands)	Returns (thousands)	Amount (millions)
Joint returns:		
0 to $10	1,167	$903
$10 to $20	2,466	1,962
$20 to $30	1,019	324
$30 to $40	160	67
$40 to $50	23	10
$50 to $75	28	26
$75 to $100	0	0
$100 to $200	0	0
$200 and over	0	0
Totals	4,863	$3,291
Percent distribution	42.5	39.7
Head of household and single returns:		
0 to $10	2,511	$1,746
$10 to $20	3,076	2,767
$20 to $30	932	432
$30 to $40	54	38
$40 to $50	13	16
$50 to $75	1	0
$75 to $100	0	0
$100 to $200	0	0
$200 and over	0	0
Totals	6,587	$5,000
Percent distribution	57.5	60.3
All returns:		
0 to $10	3,676	$2,648
$10 to $20	5,541	4,729
$20 to $30	1,952	756
$30 to $40	214	105
$40 to $50	37	25
$50 to $75	28	26
$75 to $100	2	1
$100 to $200	0	0
$200 and over	0	0
Totals	11,450	$8,291
Percent distribution	100.0	100.0

Source: Joint Committee on Taxation.

TABLE 21.—EITC PARTICIPATION BY STATE, 1988

State	Number of returns (thousands)	Number of returns with EITC (thousands)	Percent of returns with EITC	Amount (dollars in thousands)
U.S. total	110,348	11,149	10.1	5,940,882
Alabama	1,624	277	17.1	156,275
Alaska	336	16	4.8	7,204
Arizona	1,520	180	11.8	96,526
Arkansas	932	159	17.1	87,371
California	13,012	1,376	10.6	754,415
Colorado	1,493	136	9.1	70,746
Connecticut	1,676	70	4.2	33,810
Delaware	316	27	8.5	14,291
District of Columbia	324	40	12.3	20,420
Florida	5,760	636	11.0	349,276
Georgia	2,741	382	13.9	210,378
Hawaii	521	38	7.3	18,349
Idaho	391	49	12.5	25,450
Illinois	5,196	446	8.6	231,069
Indiana	2,444	227	9.3	118,971
Iowa	1,225	95	7.8	47,544
Kansas	1,077	94	8.7	47,414
Kentucky	1,462	197	13.5	106,466
Louisiana	1,625	300	18.5	168,052
Maine	560	49	8.8	24,820
Maryland	2,281	178	7.8	91,590
Massachusetts	2,958	140	4.7	68,151
Michigan	4,071	291	7.1	147,176
Minnesota	1,955	122	6.2	60,193
Mississippi	970	277	23.4	131,110
Missouri	2,224	232	10.4	122,113
Montana	341	40	11.7	20,856
Nevada	538	49	9.1	25,840
New Hampshire	551	29	5.3	14,430
New Jersey	4,012	277	6.9	141,900
New Mexico	623	105	16.9	56,536
New York	8,066	711	8.8	371,120
North Carolina	2,930	389	13.3	214,080
North Dakota	279	28	10.0	13,922
Ohio	4,910	398	8.1	203,503
Oklahoma	1,261	170	13.5	91,095
Oregon	1,245	115	9.2	59,953
Pennsylvania	5,416	413	7.6	210,361

TABLE 21.—EITC PARTICIPATION BY STATE, 1988—Continued

State	Number of returns (thousands)	Number of returns with EITC (thousands)	Percent of returns with EITC	Amount (dollars in thousands)
Rhode Island	473	31	6.6	15,630
South Carolina	1,463	222	15.2	123,444
South Dakota	299	33	11.0	16,983
Tennessee	2,097	296	14.1	160,502
Texas	7,005	1,052	15.0	576,551
Utah	634	63	9.9	32,028
Vermont	262	20	7.6	9,872
Virginia	2,775	240	8.6	127,356
Washington	2,129	164	7.7	83,199
West Virginia	679	89	13.1	46,610
Wisconsin	2,169	144	6.6	72,626
Wyoming	199	20	10.1	10,191

Source: Statistics of Income Bulletin, Spring 1990.

EXCLUSION OF PUBLIC ASSISTANCE AND SSI BENEFITS

Legislative history

While there is no specific statutory authorization, a number of revenue rulings under Code section 61 have held specific types of public assistance payments are excludable from gross income. Revenue rulings generally exclude Government transfer payments from income because they are considered to be general welfare payments. While no specific rationale has been advanced for this exclusion, the reasoning may be similar to that for the original exclusion of Social Security payments—that they are in the nature of gifts and that the Congress did not intend to tax with one hand what it pays out with the other. Also, taxing benefits provided in kind, rather than in cash (e.g., Medicaid), would require valuation of these benefits, which would create administrative difficulties.

Explanation of provision

The Federal Government provides public assistance benefits tax free to individuals either in the form of cash payments or by providing certain goods and services free of charge. Cash payments come mainly from the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. In-kind payments include food stamps, Medicaid, and housing assistance. These payments are not subject to income tax.

DEPENDENT CARE CREDIT

Legislative history

Under section 21 of the Internal Revenue Code, a tax credit is allowed with respect to certain employment-related expenses for dependent care. The origin of the credit was a provision enacted in section 214 of the Internal Revenue Code of 1954, providing a deduction to gainfully employed women, widowers, and legally separated or divorced men for certain employment-related dependent care expenses. The deduction was limited to $600 per year and phased out for families with income between $4,500 and $5,100. The intent of the provision was to recognize that, while having personal consumption characteristics, certain dependent care expenses are sufficiently similar to employee business expenses to justify a limited tax benefit.

The Revenue Act of 1964 made husbands with incapacitated wives eligible for the dependent care deduction and raised the threshold for the income phaseout from $4,500 to $6,000.

The Revenue Act of 1971 made any individual maintaining a household eligible for the deduction (subject to a gainful employment requirement). The 1971 Act also (1) modified the definition of a dependent, (2) raised the deduction limit to $4,800 per year, (3) increased from $6,000 to $18,000 the income level at which the deduction began to be phased out, (4) allowed the deduction for household services in addition to direct dependent care, and (5) limited the deduction with respect to services outside the taxpayer's household. The 1971 amendment was intended to encourage the hiring of domestic workers, encourage the care of incapacitated persons at home rather than in institutions, and provide relief to middle- and low-income taxpayers.

The Tax Reduction Act of 1975 increased from $18,000 to $35,000 the income level at which the deduction began to be phased out.

The Tax Reform Act of 1976 replaced the deduction with a nonrefundable credit. This change was made because the Congress believed that (1) the benefits of this provision should not be limited to taxpayers who itemize deductions, (2) a tax credit would provide relatively more benefit than a deduction to taxpayers in the lower tax brackets, (3) the prior rules governing married couples, divorced and separated persons, and payments to relatives were unduly restrictive, and (4) computation of the deduction was too complex.

The Revenue Act of 1978 further modified the rules relating to whether payments to relatives qualify as creditable expenses. In the Economic Recovery Tax Act of 1981, Congress provided (1) a higher ceiling on creditable expenses, (2) a larger credit for lower income individuals, and (3) modified rules relating to care provided outside the home.

In the Omnibus Budget Reconciliation Act of 1987, the credit was amended to make expenses incurred for an overnight camp ineligible for the credit.

The Family Support Act of 1988 made several alterations to the operation of the credit. The Family Support Act provided that (1) a child must be under the age of 13 (rather than 15) to be treated as an individual for whom the dependent care credit may be claimed,

(2) the amount of expenses eligible for the dependent care credit is reduced, dollar for dollar, by the amount of expenses excludable from that taxpayer's income under the dependent care exclusion, and (3) the dependent care credit may not be claimed unless the taxpayer reports on his or her tax return the correct name, address, and taxpayer identification number (TIN) of the dependent care provider.

TABLE 22.—DEPENDENT CARE CREDIT, 1976–96

Calendar year	Returns claiming dependent credit (thousands)	Amount of credit claimed (millions)	Average credit per return
1976	2,660	$548	206
1977	2,910	521	179
1978	3,431	654	191
1979	3,833	793	207
1980	4,231	956	226
1981	4,578	1,148	251
1982	5,004	1,501	300
1983	6,367	2,051	322
1984	7,546	2,649	351
1985	8,417	3,127	372
1986	8,950	3,398	380
1987	8,520	3,438	404
1988 [1]	9,002	3,807	423
1989 [1]	6,043	2,442	404
1990 [2]	6,592	2,739	416
1991 [2]	7,191	3,073	427
1992 [2]	7,309	3,188	436
1993 [2]	7,426	3,309	446
1994 [2]	7,552	3,432	454
1995 [2]	7,666	3,566	465
1996 [2]	7,789	3,701	475

[1] Preliminary.

[2] Projection.

Source: Joint Committee on Taxation.

The Omnibus Budget Reconciliation Act of 1990 amended the earned income tax credit to provide a supplemental young child credit for taxpayers with any qualifying children under the age of one. If a taxpayer claims the supplemental young child credit, the child that qualifies the taxpayer for such credit is not a qualifying individual for tax purposes of the dependent care credit.

Explanation of provision

A nonrefundable credit against income tax liability is available for up to 30 percent of a limited amount of employment-related dependent care expenses. Eligible employment-related expenses are limited to $2,400, if there is one qualifying individual, or $4,800, if there are two or more qualifying individuals. The credit may be claimed by an individual who maintains a household that includes one or more qualifying individuals. Generally, a qualifying individual is a dependent under the age of 13, a physically or mentally incapacitated dependent, or a physically or mentally incapacitated spouse.

If a taxpayer claims the supplemental young child credit as part of the earned income tax credit, the child that qualifies the taxpayer for such credit is not a qualifying individual for purposes of the dependent care credit.

Employment-related dependent care expenses are expenses for the care of a qualifying individual incurred to enable the taxpayer to be gainfully employed, other than expenses incurred for an overnight camp. For example, amounts paid for the services of a housekeeper generally qualify if such services are performed at least partly for the benefit of a qualifying individual; amounts paid for a chauffeur or gardener do not qualify.

The amount of employment-related expenses that may be taken into account in computing the credit generally may not exceed an individual's earned income or, in the case of married taxpayers, the earned income of the spouse with the lesser earnings. (This limitation does not apply in the case of a spouse who is a full-time student or who is incapable of caring for himself or herself.) Thus, if one spouse is not working, no credit generally is allowed. Also, the amount of expenses eligible for the dependent care credit is reduced, dollar for dollar, by the amount of expenses excludible from that taxpayer's income under the dependent care exclusion (discussed below).

The 30-percent credit rate is reduced, but not below 20 percent, by 1 percentage point of each $2,000 (or fraction thereof) of adjusted gross income (AGI) above $10,000. Because married couples are required to file a joint return to claim the credit, a married couple's combined AGI is used for purposes of this computation.

Effect of provision

From 1976 to 1988, utilization of the dependent care credit increased from 2.7 to 9.0 million families, the amount of credits claimed increased from $0.5 billion to $3.8 billion, and the average amount of credit claimed per family increased from $206 to $423 (see table 22). The number claiming the credit fell in 1987 because tax entry income levels (the income level at which a family begins to pay income tax) increased in 1987 as a result of the 1986 Tax Reform Act.

Changes made in the Family Support Act of 1988 generally reduced the attractiveness of the dependent care credit. The impact can be seen in the dramatic drop in utilization of the credit that occurred in 1989. Nearly three million fewer taxpayers claimed the credit in 1989 than in 1988, and the amount of credit claimed declined by $1.35 billion. The average credit claimed, though, remained relatively constant.

Most of the dependent care credit is claimed by families filing joint returns. In 1991, approximately 70 percent of the dependent care credit is projected to be claimed on joint returns and 28 percent on head of household returns (see table 23). (A small amount of dependent care credit is claimed on single returns by custodial parents who are not eligible to claim dependent exemptions.)

In 1991, less than 5 percent of the dependent care credit claimed on joint returns will be claimed by taxpayers with less than $20,000 in income (the concept of income used here is somewhat more expensive than adjusted gross income). By comparison, almost 35 percent of the credit claimed on head of household returns was attributable to returns with less than $20,000 in income. The difference reflects the fact that two-earner households, on average, have higher incomes than single-earner households.

TABLE 23.—DISTRIBUTION OF DEPENDENT CARE CREDIT BY INCOME, 1991

[Returns in thousands, amount in millions] [1]

Income class (thousands)	Joint returns				Heads of household returns				Single returns	
	Returns	Amount	Average amount claimed	Percent claiming credit [3]	Returns	Amount	Average amount claimed	Percent claiming credit [3]	Returns	Amount
$0 to $10	1	([2])	$50	([4])	14	([2])	$36	0.5	3	([2])
10 to 20	143	$49	343	2.7	733	$298	407	21.5	66	$32
20 to 30	534	177	331	6.6	627	344	549	26.0	23	8
30 to 40	863	337	390	10.9	258	127	492	20.8	1	([2])
40 to 50	1,030	409	397	14.0	123	67	545	21.1	2	1
50 to 75	1,757	765	435	14.7	70	28	400	19.9	([2])	([2])
75 to 100	610	279	457	14.1	10	4	400	20.4	3	([2])
100 to 200	267	120	449	9.4	3	1	333	8.6	([2])	([2])
200 & over	47	25	532	4.4	([2])	([2])	500	4.2	([2])	([2])
Totals	5,252	2,161	411	10.3	1,841	869	472	17.3	98	42

[1] Number of returns excludes individuals who are dependents of other taxpayers.

[2] Less than $500,000.

[3] Computation is based on the taxable returns where the credit is claimed over aggregate filers.

[4] Less than 1 percent.

Source: Joint Committee on Taxation.

The projected average dependent care credit claimed on joint returns in 1991 is projected to be $411, $61 less than the projected average of $472 claimed on head of household returns (see table 23).

Less than 1 percent of head of household returns with income less than $10,000 are projected to claim the dependent care credit in 1991, compared to over 20 percent for head of household returns with income between $10,000 and $30,000. This reflects the fact that families with income below the Federal income tax threshold are generally unable to benefit from the dependent care credit which is not refundable.

TABLE 24.—CHILD CARE CREDIT CLAIMABLE FOR RETURNS WITH MAXIMUM ALLOWABLE CHILD CARE EXPENSE ELIGIBLE FOR CREDIT, 1992

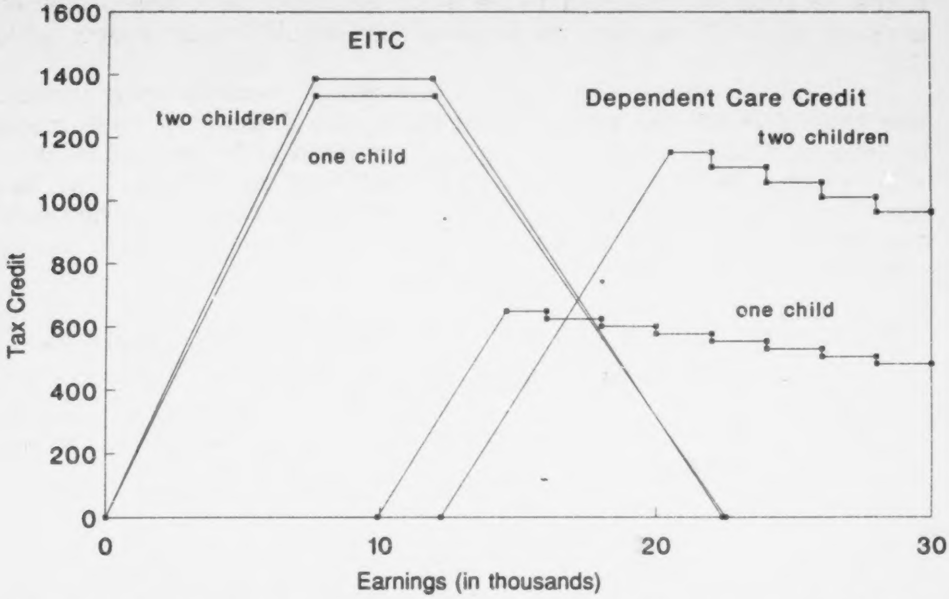
Adjusted gross income [1]	Joint return		Head of household	
	1 dependent	2 dependents	1 dependent	2 dependents
$10,000 [2]	$0	0	$15	0
$14,000	165	0	615	$270
$18,000	624	$420	624	870
$22,000	576	1,020	576	1,152
$26,000	528	1,056	528	1,056
$28,001 and above	480	960	480	960

[1] Table assumes taxpayer does not itemize deductions and all income is wages and salaries.

[2] The amount of credit that can be claimed may be less than the statutory maximum because the taxpayer has insufficient tax liability before application of the credit to get the benefit of the maximum statutory credit.

Source: Committee on Ways and Means staff.

CHART 1. THE EARNED INCOME AND DEPENDENT CARE CREDITS, 1992



Note: The dependent care credit is for a head of household with maximum allowable child care expenses eligible for the credit.

EXCLUSION FOR EMPLOYER-PROVIDED DEPENDENT CARE

Legislative history

The Economic Recovery Tax Act of 1981 added section 129 of the Internal Revenue Code, under which certain employer-provided dependent care is excluded from the employee's gross income. The 1981 Act also amended Code section 3121(a)(18) and section 3306(b)(13) to exclude such employer-provided dependent care from wages for purposes of the Federal Insurance Contributions Act (FICA) and the Federal Unemployment Tax Act (FUTA). Certain technical amendments were made to section 129 in the Technical Corrections Act of 1982 and in the Deficit Reduction Act of 1984. The Tax Reform Act of 1986 further amended Code section 129 by modifying the nondiscrimination rules and by limiting the exclusion to $5,000 a year ($2,500 in the case of a separate return by a married individual).

The Family Support Act of 1988 provided that the amount of expenses eligible for the dependent care credit is reduced, dollar for dollar, by the amount excluded from income under a dependent care assistance program. The Omnibus Budget Reconciliation Act of 1989 modified the nondiscrimination rules relating to the exclusion.

The dependent care exclusion is intended to provide an incentive for employers to provide dependent care benefits to their employees.

Explanation of provision

Section 129 of the Internal Revenue Code provides that amounts paid or incurred by an employer for dependent care assistance provided to an employee generally are excluded from the employee's gross income if the assistance is furnished under a program meeting certain requirements. These include requirements that the program is in writing, that the program satisfy certain nondiscrimination rules, and that reasonable notification of the program is provided to eligible employees. The type of dependent care eligible for the exclusion is the same as the type of expenses eligible for the dependent care credit. The dependent care credit may not be claimed with respect to amounts excluded from gross income under the provision.

With respect to any taxpayer (including a married couple filing a joint return), the dependent care exclusion is limited to $5,000 in a year ($2,500 in the case of a married taxpayer filing a separate return). Amounts excluded from gross income generally are excludable from wages for employment tax purposes.

Effect of provision

The exclusion provides an incentive for compensation to be furnished in the form of dependent care assistance, rather than in cash subject to taxation. As is the case with any deduction or exclusion, this incentive is of greater value to employees in higher tax brackets.

Many employees covered by the exclusion for employer-provided dependent care also are eligible to use the dependent care tax credit. While the limitations on the exclusion and the credit differ, the credit generally is less valuable than the exclusion for taxpayers who are above the 15-percent tax bracket.

TARGETED JOBS TAX CREDIT

Legislative history

Congress enacted the targeted jobs tax credit (sec. 51 of the Internal Revenue Code) in the Revenue Act of 1978 to replace an expiring credit for increased employment. The targeted jobs credit is intended to provide an incentive for hiring specific, targeted groups of individuals. The groups eligible for the credit consist of individuals who are (1) recipients of payments under means-tested transfer programs, (2) economically disadvantaged (as measured by family income), or (3) disabled.

As initially enacted, the targeted jobs credit was allowed for qualified wages paid before 1982. Availability of the credit was subsequently extended by the Economic Recovery Tax Act of 1981 (ERTA), the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Deficit Reduction Act of 1984 and the Tax Reform Act of 1986 ("the 1986 Act"). The Technical and Miscellaneous Revenue Act of 1988 ("the 1988 Act") the Omnibus Budget Reconciliation Act of 1989 ("the 1989 Act") and the Omnibus Budget Reconciliation Act of 1990 ("the 1990 Act") also extended the availability of the credit. The credit expires for individuals hired after December 31, 1991.

In addition, ERTA, TEFRA, and the 1984 Act altered the targeted group definitions and made several administrative and technical changes in the credit provisions. The 1986 Act generally reduced the maximum credit per year, limited to one year the period per employee for which the credit may be claimed, and established a minimum employment period for credit eligibility. The 1988 Act restricted the category of economically disadvantaged youth to include only employees aged 18 through 22, reduced the credit percentage for disadvantaged summer youth employees from 85 to 40 percent and extended the authorization for appropriations for administrative and publicity expenses to fiscal year 1989. The 1989 Act extended the credit for nine months with a modification to the certification process and extended the authorization for appropriations for administrative and publicity expenses to fiscal year 1990. The modification requires that employers: (1) specifically identify up to two categories for which the individual is believed to be eligible when requesting certification; and (2) indicate that a good faith effort was made to determine the individual is eligible for the credit. The 1990 Act extended the authorization for appropriation for administrative and publicity expenses for fiscal years in the future as deemed necessary.

Explanation of provision

The targeted job tax credit is available to employers on an elective basis for hiring individuals from nine targeted groups. The targeted groups are: (1) vocational rehabilitation referrals; (2) economically disadvantaged youths aged 18 through 22; (3) economically disadvantaged Vietnam-era veterans; (4) Supplemental Security Income (SSI) recipients; (5) general assistance recipients; (6) economically disadvantaged cooperative education students aged 16 through 19; (7) economically disadvantaged former convicts; (8) Aid to Families with Dependent Children (AFDC) recipients and Work Incentive (WIN) registrants; and (9) economically disadvantaged summer youth employees aged 16 or 17. Targeted group membership must be certified.

An individual is a member of an economically disadvantaged family if the designated local agency determines that the family had an income during the previous 6-month period which, when annualized, would be 70 percent or less of the Bureau of Labor Statistics lower living standard income level. These income levels vary by geographic region, with the highest levels generally applying to metropolitan areas in the Northeast and the lowest levels generally applying to nonmetropolitan areas in the Southeast.

The credit generally is equal to 40 percent of the first $6,000 of qualified first-year wages paid to a member of a targeted group. Thus, the maximum credit generally is $2,400 per individual. With respect to economically disadvantaged summer youth employees, however, the credit is equal to 40 percent of up to $3,000 of wages, for a maximum credit of $1,200.

The credit is not available for wages paid to a targeted group member unless the individual either (1) is employed by the employer for at least 90 days (14 days in the case of economically disadvantaged summer youth employees), or (2) has completed at least 120 hours of work performed for the employer (20 hours in the case of economically disadvantaged summer youth employees). Also the employer's deduction for wages must be reduced by the amount of the credit.

An employer who faces a 34 percent marginal tax rate and who does not claim the targeted jobs tax credit pays an after-tax cost of 66 cents for each dollar of wages paid, since the wage payment is ordinarily deductible. A similarly situated employer who claims the credit would incur an after-tax cost of 39.6 cents for each dollar of qualified wages. This figure reflects the tax savings due to the credit (40 cents) plus the value of a 60 cent tax deduction (the dollar in wages less the amount of credit claimed), which is worth 20.4 cents to a 34 percent marginal rate taxpayer.

Under the Omnibus Budget Reconciliation Act of 1987, the credit is no longer available for wages paid to a targeted-group individual who performs the same or substantially similar services as an employee participating in, or affected by, a strike or lockout.

Effect of provision

The targeted jobs tax credit serves as a subsidy to the employer for hiring targeted group members. For example, the targeted jobs credit would provide an effective subsidy of nearly 19 percent of the first-year wages of a full-time employee hired at the minimum wage ($4.25 per hour) by a corporate employer.[23]

TABLE 25.—VOUCHERS AND CERTIFICATIONS BY TARGETED GROUP, FISCAL YEAR 1989 [1]

Targeted group	Vouchers		Certifications	
	Number	Percent [2]	Number	Percent [2]
Economically disadvantaged youths 18 to 24	316,238	41.9	230,998	51.1
Economically disadvantaged Vietnam-era veterans	26,403	3.5	14,570	3.3
Economically disadvantaged former convicts	69,802	9.2	24,795	5.5
Economically disadvantaged summer youth	24,634	3.3	17,450	3.9
General assistance recipients	33,265	4.4	17,428	3.9
SSI recipients	11,641	1.5	7,433	1.6
AFDC recipients and WIN registrants	198,005	26.2	99,127	21.9
Vocational rehabilitation referrals	75,342	10.0	40,652	9.0
Total [3]	755,330	100.0	452,453	100.0

[1] A voucher is a preliminary determination that an individual is a member of a targeted group. A certification is a final eligibility determination, issued upon the request of a hiring employee.

[2] Due to rounding, percentages may not add to totals.

[3] Does not include certifications of economically disadvantaged cooperative education students. Such certifications are issued by participating schools rather than State employment security agencies which issue certifications for all targeted groups.

Source: U.S. Department of Labor.

---

[23] Assume a corporation hired a member of a targeted group full-time at the minimum wage of $4.25 an hour. Wage payments to the employee would be $8,500 and the credit to the employer would be $2,400. The employer is not permitted to deduct wage payments equal to the amount of the credit so, at a 34 percent tax rate, the effective subsidy would be $1,584.

Over 452,000 employees qualifed for the targeted jobs tax credit in 1989 (see table 25). The net increase in U.S. employment is probably less than this amount because some of these employees might have been hired without the credit, and some noncredit eligible employees might have been displaced by the targeted jobs credit program.

Table 26 shows that certifications of eligibility for the targeted jobs tax credit increased from 306,000 in 1980 to 452,000 in 1989.

TABLE 26.—VOUCHERS AND CERTIFICATIONS, 1979–89

	Vouchers (thousands)	Certifications [1] (thousands)
Fiscal year:		
1979 [2]	84	37
1980	617	306
1981	734	412
1982	625	202
1983	1,287	431
1984	1,338	563
1985	1,343	622
1986	([3])	([3])
1987	1,143	569
1988	842	497
1989	755	452

[1] Does not include certificates of economically disadvantaged cooperative education students. Such certifications are issued by participating schools rather than State employment security agencies which issue certification of all other targeted groups.

[2] First year targeted jobs tax credit was available.

[3] Not available.

Source: U.S. Department of Labor.

EXCLUSION OF WORKERS' COMPENSATION AND SPECIAL BENEFITS FOR DISABLED COAL MINERS

Legislative history

Workers' compensation.—Under section 104(a)(1) of the Internal Revenue Code of 1986, workers' compensation benefits generally are not taxable. Present law provides, however, that workers' compensation benefits are treated as social security benefits to the extent such benefits reduce social security benefits received (see above). This exclusion from gross income was first codified in the Revenue Act of 1918. The Ways and Means Committee report for that Act suggests that such payments were not subject to tax even prior to the 1918 Act.

The rationale for this exclusion is not offered in the legislative history; however, several arguments frequently are made for maintaining this exclusion. One such argument is that it is inequitable to tax payments that are in lieu of damages under State tort law, while continuing to exclude from income actual damage payments on account of personal injuries or sickness (Code sec. 104(a)(2)). Another argument is that eliminating the exclusions for wage replacement payments could cause employers and State and local governments to alter their wage replacement programs to take account of the recipients' tax liability. This might increase the overall expenditures required to maintain these programs. Alternatively, net benefits to recipients might be reduced by the imposition of tax.

Benefits for disabled coal miners.—Payments made to coal miners or their survivors for death or disability resulting from pneumoconiosis (black lung disease) under the Federal Coal Mine Health and Safety Act of 1969 (as amended by the Black Lung Benefits Act of 1972, the Black Lung Benefits Reform Act of 1977, and the Black Lung Benefits Revenue Act of 1981) are excluded from gross income.

Payments made as a result of claims filed before December 31, 1972, originally were excluded from Federal income tax by the Federal Coal Mine Health and Safety Act of 1969. Later payments are excluded from gross income because they are considered to be in the nature of workers' compensation (Rev. Rul. 72-400, 1972-2 C.B. 75).

Explanation of provision

Workers' compensation.—Present law provides that gross income does not include amounts received under workers' compensation acts as compensation for personal injuries or sickness. This exclusion also applies to benefits paid under a workers' compensation act to a survivor of a deceased employee.

Benefits for disabled coal miners.—Under present law, benefits for disabled coal miners (black lung benefits) are not includible in gross income.

There are two types of black lung programs. The first involves Federal payments to coal miners and their survivors due to death or disability, payable for claims filed before July 1, 1973 (Dec. 31, 1973, in the case of survivors). Monthly cash benefits are related to the GS-2 civil service pay scale and number of dependents. This program provided total annual payments of around $900 million to approximately 230,000 beneficiaries in 1989.[24]

The second program requires coal mine operators to insure payment of black lung benefits for claims filed on or after July 1973 (December 31, 1973, in the case of survivors) in a federally mandated workers' compensation program. Benefits include medical treatment as well as cash payments which, in general, are the same as provided under the program described above. These benefits are paid from a trust fund financed by an excise tax on coal production if there is no responsible operator (an operator for whom the miner worked 1 year) or if the responsible operator is in default. This program provided total annual payments of around $610 million to approximately 156,550 claimants in 1986.[25]

---

[24] Social Security Bulletin, various issues.

[25] Department of Labor, Employment Standards Administration, "Annual Report on Administration of Black Lung Benefits Act During Calendar Year 1986," January 1989, tables 3 and 6.

ADDITIONAL STANDARD DEDUCTION FOR THE ELDERLY AND BLIND

Legislative history

From 1954 through 1986, an additional personal exemption was allowed for a taxpayer or a spouse who was 65 years or older at the close of the year. An additional personal exemption also was allowed for a taxpayer or a spouse who was blind. The additional personal exemption was provided because the Congress concluded that the tax law should allow additional tax relief to elderly and blind individuals.

The Tax Reform Act of 1986 repealed the additional personal exemption for the elderly and blind and replaced it with an additional standard deduction amount.

Explanation of provision

Beginning in 1987, the Tax Reform Act of 1986 provided tax relief to the elderly or blind (apart from reduced tax rates) through an additional standard deduction amount, in lieu of an extra personal exemption. The additional amount is $650 for an elderly or a blind individual who is married (whether filing jointly or separately) or is a surviving spouse, and $1,300 for such an individual who is both elderly and blind. An additional standard deduction amount of $850 is allowed for a head of household who is elderly or blind ($1,700, if both), and for a single individual (i.e., an unmarried individual other than a surviving spouse or head of household) who is elderly or blind ($1,700, if both). These additional standard deduction amounts are adjusted for inflation.

The definitions of elderly and blind status have not been changed since 1954. An elderly person is an individual who has reached or passed 65 years of age. Blindness is defined in terms of the ability to correct a deficiency in distance vision or the breadth of the area of vision. An individual is blind only if central vision acuity is not better than 20/200 in the better eye with correcting lenses, or if visual acuity is better then 20/200, but is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

Effect of provision

The additional standard deduction provided by the 1986 Act increases the tax threshold for elderly and blind taxpayers. The additional amount is $1,300 for two elderly individuals on a joint return, raising the tax threshold in 1991 from $10,000 to $11,300.

In 1991, it is estimated that over 50 percent of the beneficiaries of this tax provision have incomes of less than $30,000. As table 27 shows, these taxpayers receive over 40 percent of the tax benefits from the additional standard deduction.

TABLE 27.—DISTRIBUTION OF TAX EXPENDITURE: ADDITIONAL STANDARD DEDUCTION FOR THE ELDERLY AND BLIND, 1991

Income class (thousands)	Returns (thousands)	Amount (millions)	Average per return
0 to $10	191	$21	$110
$10 to $20	1,996	241	121
$20 to $30	3,292	441	134
$30 to $40	2,276	376	165
$40 to $50	1,358	227	167
$50 to $75	1,008	244	242
$75 to $100	253	73	289
$100 to $200	88	24	273
$200 and over	24	7	292
Total	10,486	$1,654	$158

Source: Joint Committee on Taxation.

TAX CREDIT FOR THE ELDERLY AND CERTAIN DISABLED INDIVIDUALS

Legislative history

The present tax credit for individuals who are age 65 or over, or who have retired on permanent and total disability, was enacted in the Social Security Amendments of 1983 (Code sec. 22). This credit replaced the previous credit for the elderly, which had been enacted in the Tax Reform Act of 1976. Prior to that provision, the tax law provided a retirement income credit, which initially was enacted in the Internal Revenue Code of 1954.

The retirement income credit was intended to remove inequities between individuals who received retirement income which was not tax-exempt and those who received Social Security payments which were tax-exempt. The retirement income credit was applicable to retirement income only. In 1976, the tax credit for the elderly was enacted to (1) restore the purchasing power of the maximum amount of income eligible for the credit, (2) eliminate the complexity of the retirement income credit, and (3) allow individuals earning any form of income, as well as individuals receiving only retirement income, to qualify for the credit.

In the Social Security Amendments of 1983, the credit for the elderly and permanently and totally disabled was enacted to provide greater equity between Social Security retirement recipients and other retirees with income below certain levels. Because the 1983 amendments provided that one-half of the amount of Social Security benefits is includible in gross income for taxpayers having adjusted gross income (computed with modifications) exceeding $25,000 for single individuals and $32,000 for joint returns, the disparity in tax treatment between Social Security and other retirement payments was lessened for taxpayers with incomes above these thresholds.

Explanation of provision

Individuals who are age 65 or older may claim a nonrefundable income tax credit equal to 15 percent of a base amount. The credit also is available to an individual, regardless of age who is retired on disability and who was permanently and totally disabled at retirement. For this purpose, an individual is considered permanently and totally disabled ("disabled") if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months. The individual must furnish proof of disability to the IRS.

In computing the amount of the credit, a maximum base amount is specified in the statute, and certain reductions are then made. The statute specifies the initial base amount to be $5,000 in the case of an unmarried elderly or disabled individual, or in the case of a married couple filing a joint return if only one spouse is eligible for the credit; $7,500, in the case of a married couple filing a joint return with both spouses eligible for the credit; or $3,750, in the case of a married couple filing separate returns. For a disabled individual who is under age 65, however, the initial base amount is the lesser of the applicable specified amount or the individual's disability income for the year. Consequently, the maximum credit available is $750 (15 percent of $5,000), $1,125 (15 percent of $7,500), or $562.50 (15 percent of $3,750), depending on the initial base amount applicable to the taxpayer.

The initial base amount is reduced by the amount of certain nontaxable income of the taxpayer, such as nontaxable pension and annuity income or nontaxable Social Security, railroad retirement, or veterans' non-service-related disability benefits. In addition, the initial base amount is reduced by one-half of the taxpayer's AGI in excess of $7,500, in the case of a single individual; $10,000, in the case of married taxpayers filing a joint return; or $5,000, in the case of married taxpayers filing separate returns. These computational rules reflect that the credit, as indicated above, is designed to provide tax benefits to individuals who receive only taxable retirement or disability income, or who receive a combination of taxable retirement or disability income plus social security benefits, that generally are comparable to the tax benefits provided to individuals who receive only Social Security benefits (including Social Security disability benefits).

To illustrate the computation of the credit, assume that a husband and wife are both 66 and file a joint return. During the year, the husband receives a taxable pension of $5,000, wages of $3,000, and Social Security benefits of $1,000. The wife receives a taxable pension of $2,000, wages of $1,000, and Social Security benefits of $400. They receive interest income of $200 on savings. The tax credit for the elderly is computed as follows:

Husband's taxable pension	$5,000
Husband's wages	3,000
Wife's taxable pension	2,000
Wife's wages	1,000

Interest on savings	200
Adjusted gross income (AGI)	11,200
Maximum amount upon which credit may be based	7,500
Less:	
Husband's Social Security benefits	1,000
Wife's Social Security benefits	400
One-half of AGI in excess of $10,000 (½ of $1,200)	600
Total	2,000
Amount on which tax credit is based ($7,500–$2,000)	5,500
Amount of credit (15 percent of $5,500)	825

Effect of provision

In 1989, $66 million in elderly and disabled credit was claimed. The utilization rate and amount of credit granted has been relatively stable since the program's inception (in 1983), as shown in table 28.

TABLE 28.—CREDIT FOR THE ELDERLY AND DISABLED, 1976–89

	Number of families who received credit (thousands)	Total amount of credit (millions)	Average credit per return
Calendar year:			
1976	1,011	$206	$204
1977	569	93	163
1978	689	145	210
1979	607	132	217
1980	562	135	240
1981	474	124	262
1982	483	131	271
1983	423	116	275
1984	475	107	225
1985	460	106	230
1986	430	86	200
1987	354	67	189
1988 [1]	350	67	191
1989 [2]	326	66	202

[1] Preliminary.

[2] Estimated.

Source: Joint Committee on Taxation.

For 1991 it is estimated that more than 99 percent of the beneficiaries of this tax provision have incomes of less than $30,000. As table 29 shows, these taxpayers receive almost 100 percent of the tax benefits from the tax credit for the elderly and disabled.

TABLE 29.—DISTRIBUTION OF TAX EXPENDITURE: CREDIT FOR THE ELDERLY AND DISABLED, 1991 [1]

Income class (thousands)	All returns		
	Returns (thousands)	Amount (millions)	Average
0 to $10	116	$31	$268
$10 to $20	132	42	320
$20 to $30	67	12	182
$30 to $40	3	([2])	167
$40 and over	0	0	0
Total	351	66	188

[1] Preliminary.

[2] Less than $500,000.

Source: Joint Committee on Taxation.

TAX EXPENDITURES RELATED TO HOUSING

Legislative history

Deductibility of mortgage interest.—Prior to the Tax Reform Act of 1986 (the 1986 Act), all interest payments on indebtedness incurred for personal use (e.g., to purchase consumption goods) were deductible in computing taxable income. The 1986 Act amended section 163(h) of the Internal Revenue Code to disallow deductions for all personal interest except for interest on indebtedness secured by a first or second home; the deductions for other personal interest were phased out over a 4-year period ending in 1990. The maximum amount of debt for which interest was deductible was limited to the fair market value of the residences, and was also limited to the basis of such homes (plus the amount of such debt used to pay certain educational or medical expenses).

In the Omnibus Budget Reconciliation Act of 1987, Congress amended Section 163(h) of the Internal Revenue Code of 1986 to further restrict the deductibility of home interest. Only two classes of interest were distinguished as deductible: interest on acquisition indebtedness and interest on home equity indebtedness. Acquisition indebtedness, defined as indebtedness secured by a residence and used to acquire or improve the residence by which it is secured, was limited to $1,000,000 ($500,000 in the case of a married individual filing a separate return). Home equity indebtedness, defined as any nonacquisition indebtedness secured by a residence (for example, a home equity loan), was limited to the lesser of (1) $100,000 ($50,000 for married taxpayers filing separately) or (2) the excess of the fair market value of the residence over the acquisition indebtedness. The exception for indebtedness related to education or medical expenses was repealed in 1987.

Deferral of capital gains from sale of principal residence.—Prior to 1951, capital gains on housing were taxed when realized. This treatment was consistent with the tax treatment of other capital assets. In 1951, Congress added section 112(n) to the Internal Revenue Code of 1939, which permitted capital gains from the sale of a principal residence to be deferred (rolled over) as long as a new principal residence was purchased within the 24-month period beginning 12 months before the date of sale of the old residence and ending 12 months after the sale of the old residence. When capital gains are rolled over, the basis of the newly purchased house must be reduced by the amount of deferred gains. The Tax Reduction Act of 1975 extended the rollover period to 18 months before or after the sale of the old residence. The Economic Recovery Tax Act of 1981 extended this rollover period to 24 months before and 24 months after the sale of the old residence.

Exclusion of capital gains for certain taxpayers.—In the Revenue Act of 1964, Congress introduced section 121 of the Internal Revenue Code of 1954, which permitted a one-time exclusion of all or part of the gain on the sale of a principal residence by an individual age 65 or over. This exclusion was limited to homeowners who had lived in the property as a principal residence for 5 out of the last 8 years before the property's sale or exchange. Furthermore, full exclusion was permitted only for houses which sold for $20,000 or less.

This exclusion was modified and expanded a number of times. In the Tax Reform Act of 1976, Congress increased the maximum house value for full exclusion of gains to $35,000. The Revenue Act of 1978 made a number of changes. First, the youngest age at which capital gains on the sale of a principal residence could be excluded was reduced from 65 to 55. Second, the residence requirement was changed to 3 years out of the past 5 years. Finally, the exclusion was changed from a limit based on the house value to a limit of $100,000 of capital gain. The Economic Recovery Tax Act of 1981 increased the maximum amount of gain that could be excluded to $125,000.[26]

Explanation of provisions

Homeowners may deduct a number of expenses related to housing as itemized deductions in computing taxable income. These include payments of interest on qualified residence debt, certain interest on home equity loans, certain payments of points (i.e., upfront interest payments) upon the purchase of a house, and payments of real property taxes. Interest on acquisition debt of $1,000,000 or less is fully deductible, as is any interest on debt secured by a residence that was incurred on or before October 13, 1987. Interest on home equity indebtedness of $100,000 is fully deductible for regular tax purposes, as long as the total amount of debt (acquisition plus home equity indebtedness) does not exceed the fair market value of the house. Interest on home equity indebtedness exceeding $100,000 (and incurred after October 13, 1987) or exceeding the difference between the fair market value of the home and the acquisition indebtedness is not deductible. However, interest paid on home equity loans is generally not deductible in computing the alternative minimum tax.

---

[26] The Technical and Miscellaneous Revenue Act of 1988 relaxed the residence requirement slightly by treating mentally or physically incapacited taxpayers, who had lived in the residence at least 1 year in the past 5 years and who had resided in a licensed facility during this period as meeting the residence requirement.

For example, a homeowner who owns a $350,000 house with an outstanding first mortgage of $200,000 can deduct the interest on an additional $100,000 debt that is secured by that house. However, a homeowner with a $250,000 house with an outstanding first mortgage of $200,000 can only deduct interest on an additional $50,000 of debt, since total home equity indebtedness cannot exceed the difference between the fair market value of the house ($250,000) and the acquisition indebtedness ($200,000).

Capital gains from the sale of residences are generally subject to tax when realized, unless one of two conditions is met. First, capital gains are not taxed if a new residence of equal or greater value is purchased or constructed within a period 24 months before to 24 months after the first residence is sold. If the price of the new residence is less than the selling price of the old residence (less any selling expenses) then the difference between the two prices must be recognized as a gain. The basis of the new residence must be reduced by the amount of the excluded gains.

For example, if a taxpayer sells a house for $250,000 that was purchased for $175,000, then $75,000 of capital gains must be recognized (included in income) unless a new house is bought within 2 years of the sale of the first house. If the new house costs more than $250,000, no gain is recognized, and the basis of the new house is reduced by $75,000 (so the gain is deferred). If the new house costs only $200,000, for example, then $50,000 must be recognized as a gain, and only $25,000 of gain is deferred. The basis of the new house is then reduced to $175,000.

Second, taxpayers age 55 or older can take a one-time exclusion of housing capital gain of up to $125,000 ($62,500 for married filing separately).

Effects of provisions

The Tax Code provides favorable treatment for housing consumption in a number of ways. Two of the largest subsidies are (1) that the imputed rental value of owner-occupied housing is not taxed and (2) that capital gains generated by investment in housing are favorably taxed (or not taxed at all). The annual economic net return to an investment in owner-occupied housing consists of the rental value of the home plus any capital gains (or losses) on the house (whether realized or not), less the interest paid on mortgage debt outstanding. Because the tax system does not include the imputed value of homeowners' rent in gross income, this part of the return is untaxed. The result is that owner-occupants effectively pay for the rental value of their home with pretax dollars, whereas renters pay for the rental value of their home with after-tax dollars.

Capital gains on owner-occupied housing are also largely untaxed. For taxpayers younger than 55, the taxes on capital gains from housing are deferred if the taxpayer purchases a residence of equal or greater value than the original residence within 2 years of the sale of the original residence. Furthermore, taxpayers older than 55 may claim a one-time exclusion from tax of $125,000 of realized capital gains that are not rolled over.

This favorable treatment of owner-occupied housing may affect both the home ownership rate and the share of total investment in housing in the United States.

Owners versus renters.—Because the Federal tax treatment of rental housing differs from the treatment of owner-occupied housing, the tax system may favor one choice over the other. The traditional view has been that the tax system encourages homeownership. Consider an investor who buys a house for $100,000 that could be rented for $10,000 per year. Excluding tax considerations, that investor would be equally well off purchasing a $100,000 bond that paid $10,000 per year in interest, and renting a similar house for $10,000. However, the investor who purchases the house pays no tax on the return to the investment (the $10,000 per year in imputed rent), whereas the investor who rents and purchases a bond pays tax on the $10,000 of interest.

The above discussion suggests that, by excluding from tax the imputed value of a homeowner's rent, the tax system encourages home ownership for all taxpayers. However, this conclusion may not be valid; the tax system may actually encouage taxpayers with low marginal tax rates to rent their homes from landlords with high marginal tax rates.

This result is driven by two observations. First, the value of the exclusion of a homeowners imputed rent is lower for taxpayers facing lower marginal rates (generally those with lower incomes). Second, the tax system also provides favorable treatment to owners of rental housing. The value of this favorable tax treatment is larger for taxpayers facing high marginal tax rates. Thus, the costs of obtaining housing may be minimized when a taxpayer with a high marginal tax rate owns rental housing and rents it to a taxpayer with a low marginal rate. The rent that the landlord could profitably charge may be low enough that a taxpayer with a low marginal tax rate finds the costs of renting lower than the costs of owning. This is sometimes called a tax clientele effect.

The effect of tax clienteles on the homeownership decision has changed over time as the relative tax subsidy of rental property has changed. Prior to the Tax Reform Act of 1986, rental housing received depreciation allowances that substantially exceeded economic depreciation (the decline in the value of the property due to wear and tear), providing a large tax advantage to owners of rental property with high marginal tax rates. However, the Tax Reform Act of 1986 lowered the value of depreciation allowances on rental property and reduced the marginal tax rates of the highest tax-bracket taxpayers. This may have reduced the relative tax subsidy to rental property and weakened the effect of tax clienteles on this decision. Some studies suggest that home ownership now has tax advantages that exceed those of renting for all but the lowest income taxpayers.[27]

Investment in housing.—The tax subsidy for residential housing not only affects the choice of owning versus renting, but also affects the division of the economy's investment between housing and other capital investment. Since the consumption of housing is subsidized through the tax system, the housing stock in the United States may be larger than it would be without the tax subsidy. To the extent the amount of saving available for investment is limited, investment in plant and equipment is reduced when housing investment increases.[28]

---

[27] For example, see Jim Poterba, "Taxation and Housing Markets: Preliminary Evidence on the Effects of Recent Tax Reforms", National Bureau of Economic Research Working Paper No. 3270, February 1990. For a dissenting veiw, see Jane Gravelle, "Tax Policy and Rental Housing: An Economic Analysis," Congressional Research Service Report for Congress, June 25, 1987.

Deductibility of mortgage interest as a tax expenditure.—The net economic income a homeowner earns on his or her house is equal to the implicit rent on the house minus any interest payments and maintenance costs plus any accrued capital gains or losses. However, imputed income from owner-occupied housing and other consumer durables is difficult to measure, and the concept of income used to define tax expenditures does not include this imputed income. The tax expenditure related to owner-occupied housing is therefore equated with the value of the deductibility of home mortgage interest. The effect of this deductibility, given the exclusion of imputed rental income, is to subsidize not only the consumption of housing services out of housing equity (the value of the house less the outstanding debt), but the consumption of all housing services, regardless of the amount of debt. This treatment increases the subsidy to housing, and subsidizes the consumption of owner-occupied housing for all homeowners, not only those with substantial housing equity.

The following example explains this distinction by comparing the tax liabilities of homeowners under three possible tax regimes.

Consider the case of homeowner with $40,000 of equity in a house with a fair market value of $100,000. Assume the interest payments on the remaining $60,000 of mortgage indebtedness are $6,000 per year, and that the house could be rented for $10,000 per year. If this investment were treated like other investments, then tax would be paid on the return to this investment less interest payments. Under a tax system that used economic income as the tax base, the taxable income from this investment would be $4,000, the $10,000 imputed rental value less the interest cost of $6,000. If imputed income were not taxed, and interest were not deductible, the homeowner would not pay any tax on the return to this investment, saving the tax on the $4,000 of income generated by the housing equity. Under present law, not only is the imputed rental income ($10,000) not taxed, but the homeowner is permitted to deduct the $6,000 of interest payments. The homeowner's other taxable income is reduced by the $6,000 in interest paid, meaning the tax base is $10,000 less than true economic income (the homeowner's otherwise taxable income plus $4,000). The homeowner shields the full value of the income from housing investment, even though only 60 percent of the house consists of equity.

Effect of the Omnibus Budget Reconciliation Act of 1987.—Federal tax law modifications enacted in 1987 alter the above analysis somewhat. As described above, these modifications limited the deductibility of interest generated by debt secured by a residence. The intent behind this provision of the 1987 Act was to limit the subsidy to personal consumption financed by home equity loans. Once equity is built up in the house, the tax system subsidizes borrowing only up to $100,000 of this equity. The effect of this change may be to discourage taxpayers from consuming their housing wealth (and thus to encourage taxpayers to save in the form of housing). Another effect of this change might be to encourage longer mortgage contracts which slow the buildup of housing equity.

---

[28] One study has suggested that housing capital is 25 percent higher, and nonhousing capital is 12 percent lower than it would be if Federal tax policy provided equal treatment for all forms of capital. See Mills, Edwin S., "Dividing up the Investment Pie: Have We Overinvested in Housing?", Philadelphia Business Review, March-April 1987, 13-23.

Because the cap on deductible debt is so high, however, the effects to date are likely to be small (one estimate suggested that had the caps been in place in 1985, less than 11 percent of homeowners would have been affected.)[29] However, neither the $1,000,000 nor the $100,000 cap is indexed to inflation. If these caps are not increased, over time these caps will affect a larger number of people.

Distributional effects of the tax treatment of residential housing.—The implicit Federal tax subsidy of owner-occupied housing is equal to the tax that would be due on the net rental income of a taxpayer's home (the implicit rental value minus any interest paid on mortgages, plus any capital gains or losses). As explained above, because the rental value of homes is difficult to measure, the tax expenditures estimated are for deductibility of mortgage interest and property taxes, the deferral of capital gains, and the exclusion of capital gains for taxpayers older than 55.

Table 30 presents the distributional breakdown of the value of the deductibility of mortgage interest. The tax expenditure for home mortgage interest deductibility is estimated at $36.8 billion for 1991. Because the homeownership rate, the value of the home purchased, and the marginal tax rate generally increase as income increases, the dollar amount of the subsidy is higher for high-income individuals. As table 30 reports, over 80 percent of the estimated tax expenditure for mortgage interest deductibility is received by the approximately 20 percent of taxpayers with income greater than $50,000.

TABLE 30.—DISTRIBUTION OF TAX EXPENDITURE: DEDUCTIBILITY OF MORTGAGE INTEREST, 1991

Income (thousands)	Percent of returns, affected	Amount per affected return	Percent of total tax expenditure	Percent of total returns
Less than $10	0.11	$333	0.02	21.94
$10 to $20	3.24	422	0.85	20.38
$20 to $30	11.67	516	3.00	16.29
$30 to $40	22.76	799	6.74	12.14
$40 to $50	36.03	818	8.14	9.04
$50 to $75	57.09	1,434	30.50	12.20
$75 to $100	70.72	2,237	20.20	4.18
$100 to $200	76.07	3,107	20.03	2.77
$200 and over	73.03	4,456	10.53	1.06

Source: Joint Committee on Taxation.

---

[29] See Jim Poterba and Joyce Manchester, "Second Mortgages and Household Savings," Regional Studies and Urban Economics 19 (1989).

LOW-INCOME RENTAL HOUSING CREDIT

Legislative history

The low-income rental housing tax credit was first enacted in the Tax Reform Act of 1986 (the 1986 Act), and was intended to replace or supplement other tax incentives for low-income housing that were available. These tax incentives consisted principally of special accelerated depreciation, 5-year amortization of rehabilitation expenses, expensing of construction period interest and taxes, and tax-exempt bond financing for multifamily residential rental property. The credit, as created in the 1986 Act, was intended to provide a more efficient mechanism for encouraging the production of low-income rental housing. The Omnibus Budget Reconciliation Act of 1989 modified the credit with the goal of increasing its efficiency and attractiveness to investors. The Omnibus Budget Reconciliation Act of 1990 (the 1990 Act) further modified and extended the credit to December 31, 1991. The low-income housing credit is scheduled to expire on December 31, 1991.

Explanation of provision

A tax credit may be claimed by owners of residential rental property used for low-income rental housing. The credit is claimed annually, generally for a period of 10 years. New construction and rehabilitation expenditures for low-income housing projects are eligible for a maximum 70 percent present value credit, claimed annually for 10 years. The acquisition cost of existing projects which meet the substantial rehabiliation requirements and the cost of newly constructed projects receiving other Federal subsidies are eligible for a maximum 30 percent present value credit, also claimed annually for 10 years. These credit percentages are adjusted monthly based on an Applicable Federal Rate (AFR).

For example, the credit percentage which may be claimed annually for newly constructed buildings placed in service in January 1991 is 8.96 percent. That is, 8.96 percent of the eligible basis of the building may be claimed as a tax credit for each of the next 10 years commencing with 1991. When this stream of 10 annual credit receipts is discounted at the average of the mid-term and long-term AFRs, the net of tax value of which is 4.61 percent for January 1991, the resulting present value is equal to 70 percent of the building's eligible basis.

The credit amount is based on the qualified basis of the housing units serving the low-income tenants. A residential rental project will qualify for the credit only if (1) 20 percent or more of the aggregate residential rental units in the project are occupied by individuals with 50 percent or less of area median income, or (2) 40 percent or more of the aggregate residential rental units in the project are occupied by individuals with 60 percent or less of area median income. These income figures are adjusted for family size. The low income set-aside is elected when the project is placed in service. Maximum rents that may be charged families in units on which a credit is claimed depend on the number of bedrooms in the unit. The rent limitation is 30 percent of the qualifying income of a family deemed to have a size of 1.5 persons per bedroom (e.g., a two-bedroom unit has a rent limitation based on the qualifying income for a family of three).

Credit eligibility also depends on the existence of a 30-year extended low-income use agreement for the property. If property on which a low-income housing credit is claimed ceases to qualify as low-income rental housing or is disposed of before the end of a 15-year credit compliance period, a portion of the credit may be recaptured. The 30-year extended use agreement creates a State law right to enforce low-income use for an additional 15 years after the initial 15-year recapture period.

In order for a building to be a qualifed low-income building, the building owner generally must receive a credit allocation from the appropriate credit authority. An exception is provided for property which is substantially financed with the proceeds of tax-exempt bonds subject to the State's private-activity bond volume limitation. The low income credit is allocated by State or local government authorities subject to an annual limitation for each State based on State population. The annual credit allocation is $1.25 per resident.

Effect of provision

Comprehensive data from tax returns concerning the low income housing tax credit currently are unavailable. However, table 31 presents data from a survey of State credit allocating agencies. These data indicate that allocation of the available credit rose from approximately 20 percent in 1987, the initial year of credit availability, to nearly complete allocation in 1989, but allocation subsequently fell to 65 percent in 1990. There are several reasons why the 1990 experience may not be indicative of the long-term utilization of the credit. First, 1990 was the first year following substantial modification to the credit, including the requirement of an additional low-income commitment beyond the credit compliance period. The substantial modification may be expected to delay some utilization of the credit. Moreover, the initial allocative authority for 1990 was limited to $0.9375 per capita per State rather than the $1.25 per capita per State of 1987–89. While the Omnibus Budget Reconciliation Act of 1990 restored 1990 credit authority to $1.25 per capita per State,[30] the restoration occurred late in the calendar year and the reaction of allocation agencies and investors may have been delayed. In addition, 1990 was marked by a general economic slowdown in the real estate industry.

---

[30] The 1990 Act also extended the authority to $1.25 per capita for 1991.

TABLE 31.—ALLOCATION OF THE LOW INCOME HOUSING CREDIT, 1987–90

Years	Authority (millions)	Allocated (millions)	Percentage allocated (percent)
1987	$313.1	$62.9	20.1
1988	311.5	209.8	67.4
1989	314.2	307.2	97.8
1990	317.7	206.4	65.0

Source: Survey of State allocating agencies.

Table 32 provides a distribution by State of the allocation of the credit. Neither table 31 nor 32 reflect actual units of low-income housing placed in service, but rather only allocations of the credit to proposed projects. As such, these tables do not necessarily reflect the magnitude of the Federal tax expenditure from the low income housing credit.

TABLE 32.—UTILIZATION OF LOW-INCOME HOUSING CREDIT BY STATE, 1990

State	Maximum credit allocable (millions)	Credits allocated (millions)	Percentage allocated (percent)
Alabama	$5.15	$3.14	61.0
Alaska	.67	.05	7.5
Arizona	4.45	4.45	100.0
Arkansas	3.03	.56	18.5
California	36.33	34.72	95.6
Colorado	3.03	.56	18.5
Connecticut	4.05	3.30	81.5
Delaware	.84	.72	8.6
District of Columbia	.76	0	0
Florida	15.84	14.37	90.7
Georgia	8.05	4.06	50.4
Hawaii	1.39	0	0
Idaho	1.27	.73	57.5
Illinois	10.85	4.67	43.0
Illinois-Chicago	3.78	1.70	45.0
Indiana	6.99	4.27	61.1
Iowa	3.55	2.42	68.2
Kansas	3.93	3.91	99.5
Kentucky	4.66	3.97	85.2
Louisiana	5.48	3.77	68.8

TABLE 32.—UTILIZATION OF LOW-INCOME HOUSING CREDIT BY STATE, 1990—Continued

State	Maximum credit allocable (millions)	Credits allocated (millions)	Percentage allocated (percent)
Maine	1.53	.37	24.2
Maryland	5.87	5.20	88.6
Massachusetts	7.39	7.02	95.0
Michigan	11.59	7.47	64.5
Minnesota	6.99	2.25	32.2
Mississippi	3.28	1.88	57.3
Missouri	6.45	3.64	56.4
Montana	1.01	.19	18.8
Nebraska	1.97	1.49	75.6
Nevada	1.39	.64	46.0
New Hampshire	1.38	.18	13.0
New Jersey	9.67	4.90	50.7
New Mexico	1.91	.97	50.8
New York	22.44	9.29	41.4
North Carolina	8.21	3.19	38.9
North Dakota	.83	.67	80.7
Ohio	13.60	12.07	88.8
Oklahoma	4.05	.72	17.8
Oregon	3.53	1.60	45.3
Pennsylvania	15.05	9.79	65.0
Puerto Rico	4.11	3.22	78.3
Rhode Island	1.25	.57	45.6
South Carolina	4.39	3.25	74.0
South Dakota	.89	.80	89.9
Tennessee	6.34	2.08	32.8
Texas	21.98	10.24	46.6
Utah	2.13	1.88	88.3
Vermont	.71	.57	80.3
Virgin Islands	.14	.07	51.4
Virginia	7.62	6.76	88.7
Washington	5.95	4.73	79.5
West Virginia	2.32	.31	13.4
Wisconsin	6.08	5.44	89.5
Wyoming	.45	.09	20.7

Source: Survey of State allocating agencies.

Preliminary data from a HUD study indicate that in 1987, the first year of the credit, credits were allocated to more than 1,300 projects. The credits were given in connection with over 34,000 units of low-income housing. Sixty-five percent of these units were the result of new construction or substantial rehabilitation. Over 90 percent of the projects elected to satisfy the 60 percent of area median income test. Thirty-two percent of all units were located outside metropolitan areas.[31]

MEASUREMENT OF TAX EXPENDITURES

Estimates of tax expenditures as revenue losses are subject to important limitations. Each tax expenditure is measured in isolation. The difference between the estimate of tax liabilities under present law, which provides for a tax preference, and the higher level of tax liabilities if the provision did not exist, is the amount of the tax expenditure. For this computation, it generally is assumed that nothing else changes.

If two or more items were to be eliminated simultaneously, the result of the combination of changes might produce a lesser or greater revenue effect than the sum of the amounts shown for each item separately. This means that adding the amounts of various tax expenditure items is of quite limited usefulness.

If a tax expenditure item were to be eliminated, it is possible that Congress would deal with the underlying reason for enacting the tax expenditure in another way, rather than simply terminating Federal assistance of any kind. To the extent that a replacement program would be adopted, the higher revenues received as a result of the elimination of a tax expenditure might not represent a net budget gain. The nature of any alternative program cannot be anticipated: it could involve direct expenditures, direct loans, or loan guarantees; or it could involve a different form of tax expenditure, or a general reduction in tax rates. If any of these provisions were repealed, adjustment might be made through fiscal or monetary policy to offset the effects of higher tax liabilities on the economy, but the estimates of tax expenditures do not anticipate such policy responses.

CONCEPTS USED IN DISTRIBUTIONAL ANALYSIS

Unless otherwise specified, the income concept used to show the distribution of tax expenditures by income class is adjusted gross income plus (1) tax-exempt interest, (2) employer contributions for health plans and life insurance, (3) inside build-up on life insurance, (4) workers' compensation, (5) nontaxable social security benefits, (6) deductible contributions to individual retirement accounts, (7) minimum tax preferences, and (8) net losses, in excess of minimum tax preferences, from passive business activities (such as limited partnership activities) which reduced adjusted gross income.

This definition of income represents an attempt to include items which clearly increase the ability to pay taxes, but which are not included in the present-law definition of adjusted gross income. The adjustment for losses from certain passive business activities takes into account that investments in such activities may result in losses for tax purposes that do not represent economic losses.

---

[31] Miller, Ted R. and Paul M. Wright, "Use of the Low Income Tax Credit in 1987," The Urban Institute, HUD Contract 5773, September 27, 1988.

This income definition is subject to various limitations. It omits certain items which clearly affect ability to consume goods and services, including accrual of pension benefits, other fringe benefits (such as military benefits, veterans benefits, and parsonage allowances), means-tested transfer payments (such as Aid to Families with Dependent Children, Supplemental Security Income, food stamps, housing subsidies, and general assistance), and imputed rent on owner-occupied homes.

All income and deduction items and tax parameters are projected to 1991 levels based on economic assumptions consistent with the January 1991 forecast of the Congressional Budget Office.

The tax return is the unit of analysis in all tables, so that each income class consists of tax returns with the stated amount of income. Table 33 shows the distribution by income class of all returns.

Unless specifically indicated, all distributional tables exclude returns filed by dependents.

TABLE 33.—DISTRIBUTION BY INCOME CLASS OF ALL RETURNS, TAXABLE RETURNS, ITEMIZED RETURNS, AND TAX LIABILITY, AT 1991 RATES AND 1991 LAW AND 1991 INCOME LEVELS [1]

[Money amounts in millions of dollars, returns in thousands]

Income class (thousands) [2]	All returns [3]	Taxable returns	Itemized returns		Tax liability
			Total	Taxable	
Below $10	24,652	5,258	414	79	−$1,173
$10 to $20	22,896	14,227	1,366	648	10,401
$20 to $30	18,308	16,251	3,195	2,725	28,790
$30 to $40	13,636	13,364	4,306	4,197	40,599
$40 to $50	10,163	10,102	4,716	4,683	44,601
$50 to $75	13,709	13,639	9,211	9,191	95,668
$75 to $100	4,696	4,694	4,001	4,000	57,300
$100 to $200	3,117	3,116	2,867	2,866	71,591
$200 and over	1,190	1,189	1,106	1,105	141,727
Total	112,366	81,840	31,182	29,494	489,505

[1] Tax law as in effect on January 1, 1991, is applied to the 1991 level and sources of income and their distribution among taxpayers. Excludes individuals who are dependents of other taxpayers.

[2] The income concept used to place tax returns into classes is adjusted gross income (AGI) plus (1) tax-exempt interest, (2) employer contributions for health plans and life insurance, (3) inside build-up on life insurance, (4) workers' compensation, (5) nontaxable social security benefits, (6) deductible contributions to individual retirement accounts, (7) the minimum tax preferences, and (8) net losses, in excess of minimum tax preferences, from passive business activities.

[3] Includes filing and nonfiling units. Filing units include all taxable and nontaxable returns. Nonfiling units include individuals with income that is exempt from Federal income taxation (e.g., transfer payments, interest from tax-exempt bonds, etc.)

Note: Detail may not add to total due to rounding.

Source: Joint Committee on Taxation.

Section 13. The Pension Benefit Guaranty Corporation [1]

The Pension Benefit Guaranty Corporation (PBGC) was established under title IV of the Employee Retirement Income Security Act of 1974 (ERISA) (88 Stat. 829, Public Law 93-406) to insure private pension beneficiaries against the complete loss of promised benefits if their pension plan is terminated without adequate funding.

Explanation of the Corporation and Its Functions

ADMINISTRATION

The PBGC is a Government-owned corporation. A three-member board of directors, chaired by the Secretary of Labor, administers the Corporation. The Secretary of Commerce and the Secretary of the Treasury are the other directors. ERISA provides for a seven-member Advisory Committee, appointed by the President, for staggered 3-year terms. The Advisory Committee advises the PBGC on issues such as the appointment of trustees in termination proceedings, investment of funds, plan liquidations, and other matters as requested by the PBGC.

PLAN TERMINATION INSURANCE

Defined benefit and defined contribution plans

There are two basic kinds of pension plans: "defined benefit" and "defined contribution" plans. Under a defined benefit plan, employees receive a fixed benefit at retirement prescribed by formula. The employer makes annual contributions to the plan based on actuarial calculations designed to ensure that the plan has sufficient funds to pay the benefit prescribed by the formula. Under a defined contribution plan, no particular benefit is promised. Instead, benefits are based on the balance of an individual account maintained for the benefit of the employee. The benefit received by an employee at retirement is generally dependent on two factors: total contributions made to the plan on the employee's behalf during the employee's participation in the plan, and the investment experience of the amounts contributed on the employee's behalf. Under either type of pension plan, employees may also be permitted to make contributions.

Under a defined contribution plan, the employee bears all the risk of poor investment performance of the assets invested in a plan. Whether the investments are invested well or poorly, the employee gets at retirement only what was contributed plus the amount actually earned.

---

[1] This section draws from: a CBO report entitled "Federal Insurance of Private Pension Benefits," October 1987; the PBGC Annual Report to Congress Fiscal Year 1990; a Joint Committee on Taxation print entitled "Current Issues Relating to PBGC Premiums and Single-Employer Defined Benefit Pension Plans," May 15, 1987; and a Joint Committee on Taxation print entitled "Present Law and Issues Relating to Pension Benefit Guaranty Corporation Guarantees of Retirement Annuities Paid By Insurance Companies," April 4, 1990.

Under a defined benefit plan, the employer bears more of the risk of loss. The Internal Revenue Code and ERISA contain minimum funding standards that require the employer to make contributions to a defined benefit plan to fund promised benefits. Thus, for example, if the plan experiences poor investment performance, actuarial miscalculations, or low benefit estimates, the employer will be required to make additional contributions to the plan. However, the minimum funding rules provide for funding over a period of time, and do not require that the plan have assets to pay all the benefits earned under the plan at any particular time. Thus, it is possible for a defined benefit plan to terminate without having sufficient assets to pay promised benefits. The PBGC insures plan benefits up to certain limits to protect plan participants in the event of such a termination. However, the PBGC does not protect all benefits promised under a plan so that even under a defined benefit plan, the employees bear some risk of loss.

Defined benefit plans are fewer in number than defined contribution plans, but cover more participants and account for a greater volume of assets. In 1987, defined benefit pension plans accounted for 27 percent of all pension plans, but were the primary form of coverage for 68 percent of all pension participants and accounted for 64 percent of pension assets.

The PBGC insures benefits only under certain defined benefit plans. That is, under certain conditions, if defined benefit plan assets are not sufficient to fund promised benefits, the PBGC pays pensions to beneficiaries up to certain monthly amounts. Private defined benefit pension plans insured by the PBGC continue to be well funded in general, with about $800 billion in liabilities backed by more than $1 trillion in assets. However, the PBGC faces substantial direct exposure from a relatively small number of plans, concentrated in the steel, airline and automobile industries, with unfunded liabilities between $20 and $30 billion. The operations of the insurance program, and insurance limits, are described below. Defined contribution plans are not insured by the PBGC.

Single-employer and multiemployer plans

Defined benefit plans insured by the PBGC fall into two categories: single-employer plans and multiemployer plans. Multiemployer plans are collectively bargained arrangements maintained by more than one employer. Single-employer plans, whether or not collectively bargained, are each maintained by one employer.

The risk to the PBGC posed by single-employer plans is different from that posed by multiemployer plans. Generally, single-employer plans are more vulnerable to the risk of underfunding due to financial weakness of the sponsoring employer; the PBGC is more vulnerable to the risk that a single employer will be unable to make up the difference between funded and promised benefits. Issues concerning insurance of multiemployer plans are more likely to concern the allocation of liabilities as firms enter and leave the participating group.

The PBGC insures the benefits of nearly 40 million pension plan participants, including active workers and retirees. Of these, 79 percent, or about 31 million, are covered by approximately 93,000 single-employer pension plans, and 21 percent, or about 8 million, are covered by approximately 2,300 multiemployer plans.

Other requirements for PBGC coverage

The PBGC covers only those defined benefit plans which meet the qualification requirements of Section 401 of the Internal Revenue Code. These are also the requirements that plans must meet in order to receive the significant tax benefits available to pension plans.

Generally, to be qualified under the Internal Revenue Code, a pension plan must be established with the intent of being a permanent and continuing arrangement; must provide definitely determinable benefits; may not discriminate in favor of highly compensated employees with respect to coverage, contributions or benefits; and must cover a minimum number of participants.

Pension plans specifically excluded from insurance by the PBGC include government and church plans, defined contribution plans, plans of fraternal societies financed entirely by member contributions and plans maintained by certain professionals with 25 or fewer participants.

PLAN TERMINATION

Single-employer plans

An employer can voluntarily terminate a single-employer plan only in a standard or distress termination. The participants and the PBGC must be notified of the termination. The PBGC may involuntarily terminate a plan.

a. Standard terminations

A standard termination is permitted only if plan assets are sufficient to cover benefit liabilities. Generally, benefit liabilities equal all benefits earned to date by plan participants, including vested and nonvested benefits (which automatically become vested at the time of termination), and including certain early retirement supplements and subsidies. Benefit liabilities may also include certain contingent benefits (for example, plant shutdown benefits). If assets are sufficient to cover benefit liabilities (and other termination requirements, such as notice to employees, have not been violated), the plan distributes benefits to participants. The plan provides for the benefit payments it owes by purchasing annuity contracts from a life insurance company, or otherwise providing for the payment of benefits, for example, by providing the benefits in lump sum distributions.

Assets in excess of the amounts necessary to cover benefit liabilities may be recovered by the employer in an asset reversion. The asset reversion is included in the gross income of the employer and is also subject to a nondeductible excise tax. The excise tax is 20 percent of the amount of the reversion if the employer establishes a qualified replacement plan, or provides certain benefit increases in connection with the termination. Otherwise, the excise tax is 50 percent of the reversion.

b. Distress terminations

If assets in the plan are not sufficient to cover benefit liabilities, the employer ,may not terminate the plan unless the employer meets one of four criteria necessary for a "distress" termination:

—The contributing sponsor, and every member of the controlled group of which the sponsor is a member, is being liquidated in bankruptcy or other similar State insolvency proceedings;

—The contributing sponsor and every member of the sponsor's controlled group is being reorganized in bankruptcy or similar State proceeding;

—The PBGC determines that termination is necessary to allow the employer to pay its debts when due;

—The PBGC determines that termination is necessary to avoid unreasonably burdensome pension costs caused solely by a decline in the employer's work force.

These requirements, added by the Single Employer Pension Plan Amendments Act of 1986 (SEPPAA) and modified by the Pension Protection Act of 1987 (PPA), are designed to ensure that the liabilities of an underfunded plan remain the responsibility of the employer, rather than the PBGC, unless the employer meets strict standards of financial need indicating genuine inability to continue funding the plan.

c. Involuntary terminations

In order to terminate a plan involuntarily, the PBGC must obtain a court order. The PBGC may institute court proceedings only if the plan in question has not met the minimum funding standards, will be unable to pay benefits when due, a substantial owner has received a distribution greater than $10,000 (other than by reason of death), or the liability of the PBGC may reasonably be expected to increase if the plan is not terminated. The PBGC must terminate a plan if the plan is unable to pay benefits that are currently due. A court may order termination of the plan in order to protect the interests of participants, to avoid unreasonable deterioration of the plan's financial condition, or to avoid an unreasonable increase in the PBGC liability under the plan.

d. PBGC trusteeship

When an underfunded plan terminates in a distress or involuntary termination, the plan effectively goes into PBGC receivership. The PBGC becomes the trustee of the plan, takes control of any plan assets, and assumes responsibility for liabilities under the plan. The PBGC makes payments for benefit liabilities promised under the plan with assets received from two sources: assets in the plan before termination, and assets recovered from the employer (see below). The balance, if any, of guaranteed benefits owed to beneficiaries is paid from the PBGC's revolving funds (see below).

e. Employer liability to the PBGC

Following a distress or involuntary termination, the plan's contributing sponsor and every member of that sponsor's controlled group is liable to the PBGC for the excess of the value of the plan's liabilities as of the date of plan termination over the fair market value of the plan's assets on the date of termination. The liability is joint and several, meaning that each member of the controlled group can be held responsible for the entire liability. Generally, the obligation is payable in cash or negotiable securities to the PBGC on the date of termination. Failure to pay this amount upon demand by the PBGC may trigger a lien on the property of the contributing employer's controlled group for up to 30 percent of its net worth. Obligations in excess of this amount are to be paid on commercially reasonable terms acceptable to the PBGC.

f. Benefit payments

When an underfunded plan terminates, the benefits that the PBGC will pay depend on the statutory guaranty, asset allocation, and recovery on the PBGC's employer liability claim.

Guaranteed benefits.—Within certain limits, the PBGC guarantees any retirement benefit that was nonforfeitable (vested) on the date of plan termination other than benefits that vest solely on account of the termination, and any death, survivor or disability benefit that was owed or was in payment status at the date of plan termination. Generally only that part of the retirement benefit that is payable in monthly installments (rather, than for example, lump sum benefits payable to encourage early retirement) is guaranteed. Retirement benefits that commence before the normal age of retirement are guaranteed, provided they meet the other conditions of guarantee. Contingent benefits (for example, early retirement benefits provided only if a plant shuts down) are guaranteed only if the triggering event occurs before plan termination.

There is a statutory ceiling on the amount of monthly benefits payable to any individual that may be guaranteed. This ceiling is indexed according to changes in the Social Security wage base, and is $2,250.00 in 1991 for a single life annuity payable at age 65. This limit is actuarially reduced for benefits payable before age 65, or payable in a different form.

The guarantee for any new benefit, including benefits under new plans and benefits provided by amendment to already existing plans, is phased in over 5 years following creation of the benefit.

Asset allocation.—Assets of a terminated plan are allocated to pay benefits according to a priority schedule established by statute. Under this schedule, some nonguaranteed benefits are payable from plan assets before certain guaranteed benefits. For example, certain benefits that have been in pay status for more than 3 years have priority over guaranteed benefits not in pay status.

Section 4022(c) benefits.—The PBGC is also required to pay participants a portion of their unfunded, nonguaranteed benefits based on a ratio of recovery on the employer liability claim to the amount of that claim.

As a result of the asset allocation and section 4022(c) benefits, reimbursement to the PBGC for its payment of guaranteed benefits may be less than the total value of assets recovered from the terminated plan.

Multiemployer plans

In the case of multiemployer plans, the PBGC insures plan insolvency, rather than plan termination. Accordingly, a multiemployer plan need not be terminated to qualify for PBGC financial assistance, but must be found to be insolvent. A plan is insolvent when its available resources are not sufficient to pay the plan benefits for the plan year in question, or when the sponsor of a plan in reorganization reasonably determines, taking into account the plan's recent and anticipated financial experience, that the plan's available resources will not be sufficient to pay benefits that come due in the next plan year.

If it appears that available resources will not support the payment of benefits at the guaranteed level, the PBGC will provide the additional resources needed as a loan. The PBGC may provide loans to the plan year after year. If the plan recovers from its financial status, it must begin repaying loans on reasonable terms in accordance with regulations.

The PBGC guarantees benefits under a multiemployer plan of the same type as those guaranteed under a single employer plan, but a different guarantee ceiling applies. As a result of the Multiemployer Pension Plan Amendments Act of 1980 (Public Law 96-364, referred to as MPPAA), the limit for multiemployer plans is the sum of 100 percent of the first $5 of monthly benefits per year of credited service, and 75 percent of the next $15 of monthly benefits. (The 75 percent is reduced to 65 percent for plans that do not meet certain pre-ERISA minimum funding standards.)

MPPAA requires that PBGC conduct a study every 5 years to determine whether changes are needed in the multiemployer premium rate or guarantee. PBGC completed the second such study in 1990, confirming the program's financial solvency, but also finding that inflation had devalued the existing guarantee limits.

FINANCIAL CONDITION OF THE PBGC

OVERVIEW

According to its most recent annual report, the PBGC's multiemployer plan insurance program is in sound financial shape. Assets exceeded liabilities by $132.5 million at the end of the 1990 fiscal year.

However, by 1990, the single-employer program was showing a deficit of $1.9 billion. That is, the present value of the sum of PBGC's expected premium income, assets recovered from terminated plans, assets owed by employers to the PBGC, and investment income, fell short of the expected value of PBGC's liabilities to plan participants by this amount. This figure does not include the potential losses from three large plans of the LTV Corp. that have been the subject of extensive litigation for the past 3 years. These plans are underfunded by approximately $2.5 billion.

The case dates to January 1987, when the PBGC terminated and trusteed the three plans after the bankrupt LTV stopped funding them. The company subsequently established new follow-on pension arrangements that effectively continued LTV's original pension programs using PBGC payments as a subsidy. In response to LTV's use of follow-on plans, and in light of significant improvements in its financial condition, PBGC restored the plans to full, active operation in September 1987. LTV contested this restoration in Federal court. However, the PBGC prevailed when the Supreme Court, in an 8–1 decision, overturned rulings by the lower courts. In December 1990, a district court took the final step and ordered a full restoration of the plans.

In another major case, Eastern Air Lines' seven defined benefit plans, covering about 50,000 workers and retirees, were underfunded for full benefits by nearly $700 million as of October 1990. Eastern, in bankruptcy reorganization since March 1989, is part of a controlled group which includes Continental Airlines Holdings, Inc. (formerly Texas Air), and Continental Airlines. Even before Eastern's bankruptcy filing, the PBGC worked closely with the Internal Revenue Service to ensure that Eastern continued to meet its pension funding obligations.

The agency was particularly concerned about a breakup of the controlled group that would have left only Eastern responsible for the pension plans. In September 1990, a settlement was negotiated under which Eastern and Continental agreed to fully fund all pension benefits and to provide security arrangements acceptable to the PBGC.

In October 1990, the PBGC terminated and trusteed Eastern's plans. Eastern was obligated to pay $30 million to the plans, which occurred, and to grant the PBGC a general unsecured claim in its bankruptcy for $565 million. Continental, which paid an initial $80.5 million in September 1990, agreed to fund the remaining liability in monthly installments ending in 2002. However, Continental failed to provide collateral adequate to meet the PBGC's requirement for an acceptable security agreement. Therefore, the September 1990 agreement with Continental is void.

Continental filed for bankruptcy in December 1990 and Eastern discontinued operations in January 1991. The PBGC will seek recoveries of approximately $700 million in claims against Continental and its subsidiaries.

About $20 to $30 billion of underfunding exists in pension plans concentrated in the steel, airline, and automobile industries. This includes pension plans with about $8 billion of underfunding that are sponsored by financially troubled companies and that represent a serious risk of loss to the PBGC.

The pension plans of Pan American Airways (Pan Am) currently represent a specific example of this potential exposure to the PBGC. Pan Am has filed for protection under Chapter 11 of the Federal Bankruptcy Code. Unfunded liabilities for the plans are approximately $800 million. In the event of termination, the PBGC would seek to recover the unfunded liabilities from Pan Am.

Claims

As of 1990, the PBGC's single-employer program had incurred net claims of over $3.1 billion (see table 1). Net claims equal the value of guaranteed benefit liabilities owed by the PBGC to participants and beneficiaries of terminated plans, less assets already in those plans, and less amounts owed to the PBGC by the employers who terminated underfunded plans assumed by the PBGC. Net claims equal the amount that has to be made up through premiums, earnings on PBGC assets or other sources of revenues.

TABLE 1.—CLAIMS EXPERIENCE FROM SINGLE-EMPLOYER PLANS [1]

[Dollars in millions]

Year of termination	Number of plans	Benefit liability	Trust plan assets	Recoveries from employers	Net losses
1975–79	585	$402	$151	$59	$192
1980–84	599	1,270	512	136	622
1985–90	374	2,063	469	385	1,209
Total	1,558	3,736	1,132	580	2,024
Probable	34	4,345	2,284	950	1,111
Total	1,592	8,081	3,416	1,530	3,135

[1] Values for recent years are subject to change as PBGC completes reviewing smaller plans generally with claims of less than $5 million and establishes termination dates.

Note: Numbers may not add up to totals due to rounding.

Source: PBGC Annual Report for Fiscal Year 1990, submitted to the Congress February 1991.

Over 50 percent of the PBGC's losses incurred to date are attributable to underfunded plans from the steel and airline industries.

Table 1 demonstrates the dramatic growth in net losses over the PBGC's history, despite the decline in the number of terminations within the past few years. Most significantly, the PBGC faces probable losses of $1.1 billion for 34 plans that are expected to terminate after the end of this year.

The average net loss per plan from 1985 to 1990 (excluding probable plan terminations) was about $3.2 million. As the following table shows, this is about 10 times the average net loss of $329,000 per plan from 1975 through 1979.

TABLE 2.—TRENDS IN UNDERFUNDING CLAIMS FROM TERMINATED PLANS

[Dollars in millions]

Year of termination	Funding level (percent)	Net losses as a percent of guaranteed liability	Average net loss per terminated plan
1975–79	37	48	$0.3
1980–84	40	49	1.0
1985–90	23	59	3.2

As shown by table 3, the number of plan terminations that result in claims against the PBGC is a tiny fraction of all plan terminations.

TABLE 3.—TOTAL NUMBER OF TERMINATED SINGLE-EMPLOYER PLANS, NUMBER OF PLANS WITH CLAIMS AGAINST PBGC, AND ACCUMULATED DEFICIT

	Number of terminated plans	Number of claims against PBGC	Accumulated deficit end of year [1]
Fiscal year:			
1975	2,568	100	−15.7
1976	9,104	171	−41.0
1977	7,331	131	−95.3
1978	5,260	102	−137.8
1979	4,888	81	−146.4
1980	4,033	101	−94.6
1981	5,084	134	−188.8
1982	6,131	130	−332.8
1983	6,870	141	−523.3
1984	7,711	93	−462.0
1985	8,723	102	−1,325.3
1986	6,915	100	−3,826.4
1987	10,924	74	−1,548.5
1988	10,836	59	−1,543.3
1989	11,433	21	−1,123.6
1990	11,462	52	−1,912.8
Total	107,811	1,526	....

[1] Includes 34 plans with claims of $1 million or more that were probable terminations as of the end of fiscal year 1990.

Source: Pension Benefit Guaranty Corporation.

FINANCING

The sources of financing for PBGC are per capita premiums collected from insured plans, assets in terminated underfunded plans for which the PBGC has become trustee, investment earnings, and amounts owed to the PBGC by employers who have terminated underfunded plans. In addition, PBGC has the authority to borrow up to $100 million from the Treasury.

Single-employer premiums.—An employer who maintains a covered single-employer defined benefit pension plan must pay an annual premium for each participant under the plan. Initially set at $1 per participant, the per capita premium was raised to $2.60 beginning in 1979, and then raised again by the Single Employer Pension Plan Amendments Act (SEPPA) to $8.50 beginning in 1986. The Pension Protection Act of 1987 contained in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) raised the basic premium to $16, and imposed an additional variable rate, or risk-related, premium on underfunded plans. The variable rate premium was initially set at $6 per each $1,000 per participant of the plan's unfunded vested benefits, up to a maximum of $34. Accordingly, the maximum premium was $50 per participant.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) increased the basic premium to $19, the variable rate premium to $9 per each $1,000 per capita of the plan's unfunded vested benefits, up to a maximum of $53. Thus, beginning in 1991, the maximum premium is $72 per participant. OBRA 90 did not change the ratio of revenue raised by the basic and variable rate portions of the premium. Single-employer premium income equalled $659.4 million in 1990.

Multiemployer plan premiums.—The premium for multiemployer plans was initially $0.50 per participant. The Multiemployer Pension Plan Amendments Act raised the premium to $1.40 for years after 1980. This was set to increase gradually to its current level, $2.60. Multiemployer premium income equalled $21.2 million in 1990.

Assets from terminated plans.—When the PBGC becomes trustee of a plan, it receives control of any assets in the plan. These assets are placed in one of two trust funds (one for multiemployer plans, one for single-employer plans).

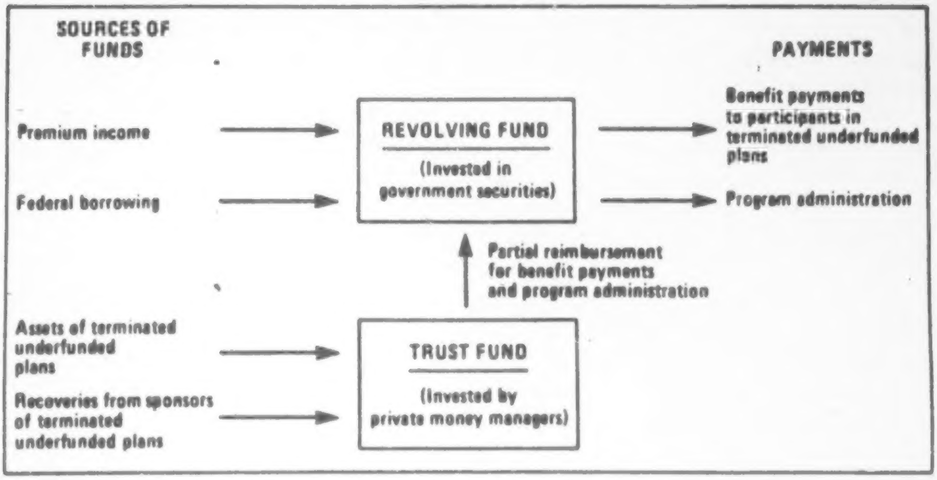
Employer liability.—An employer which terminates an underfunded defined benefit plan is liable to the PBGC for certain amounts. Before the changes made by SEPPAA, an employer's liability was generally capped at 30 percent of the employer's net worth. SEPPAA removed this limit, leaving employers whose liability would have been capped liable for an additional share of unfunded benefit commitments above 30 percent of net worth. The Pension Protection Act of 1987 further increased employer liability, leaving employers liable for all amounts up to 100 percent of unfunded benefit liabilities. Through 1990, the PBGC accumulated $346 million in liability owed by employers.

Investment income.—The PBGC maintains two separate financial programs, each consisting of a revolving fund and a trust fund, to sustain its single-employer and multiemployer plan insurance programs. Its revolving funds consist of collected premiums and income resulting from investments of the premiums. They had a net market value of $1.6 billion as of September 30, 1990.

The trust funds consist of assets received from all terminated plans of which the PBGC is or will be a trustee, and employer liability payments. These assets are invested in a diversified portfolio of investments including equities, fixed income securities, and real estate. The net market value of the trust funds was $1 billion as of September 30, 1990.

Chart 1 diagrams the relationship between the PBGC's financing and its payment of guaranteed benefits to plan participants.

CHART 1. FINANCIAL STRUCTURE OF THE PENSION BENEFIT GUARANTY CORPORATION


SOURCES OF FUNDS
PAYMENTS
Premium income
Federal borrowing
REVOLVING FUND
(Invested in government securities)
Benefit payments to participants in terminated underfunded plans
Program administration
Partial reimbursement for benefit payments and program administration
Assets of terminated underfunded plans
Recoveries from sponsors of terminated underfunded plans
TRUST FUND
(Invested by private money managers)

SOURCE: Congressional Budget Office

LEGISLATIVE HISTORY

SINGLE EMPLOYER PLANS

The PBGC was established under the Employee Retirement Income Security Act of 1974 (ERISA) for the purpose of insuring benefits under defined benefit pension plans. As originally structured, in the case of a single-employer plan, termination of the plan triggered the PBGC insurance mechanism. The contributing employer was liable to the PBGC for unfunded insured benefits up to 30 percent of the net worth of the employer. If unfunded insured liability exceeded this amount, the PBGC had to absorb the excess and spread the loss over insured plans. Employers generally faced no restrictions on their ability to terminate an underfunded plan.

The Single Employer Pension Plan Amendments Act of 1986 (SEPPAA)

By September 30, 1985, the PBGC reported that the deficit in its single-employer insurance program was $1.3 billion, and growing rapidly. Congress responded by enacting SEPPAA. Major reforms under SEPPAA, which was included as title XI of the Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272), include:

1. Raising the per-participant premium to $8.50, from $2.60.
2. Providing that an underfunded plan may be terminated only if the contributing employer, and every member of the employer's controlled group, meets certain criteria of "financial distress". As a result, employers could not place the liability for underfunded plans on the PBGC without demonstrating real financial inability to maintain and fund the plan.

3. Providing that, in addition to the liability to the PBGC under prior law for the lesser of the unfunded guaranteed benefits or 30 percent of the collective net worth of the controlled group, employer liability also included the amount by which 75 percent of unfunded guaranteed benefits exceeded 30 percent of net worth.

4. Providing that unpaid and waived contributions were due and payable in full as of the date of termination.

5. Creating a new liability to plan participants for certain nonguaranteed benefits.

Pension Protection Act of 1987

By the beginning of 1987, it became increasingly apparent that the reforms implemented under SEPPAA were inadequate to ensure the long-term solvency of the PBGC. Accordingly, Congress enacted the Pension Protection Act of 1987 as part of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), which included a number of significant reforms:

1. *Variable rate premium.*—Increasing the basic premium to $16, and instituting an additional premium that rises with the degree of underfunding in the plan and, thus, the risk posed by the plan to the PBGC.
2. *Minimum funding standards.*—Requiring faster funding of unfunded benefits, to reduce the PBGC's exposure in the event of plan termination.
3. *Employer liability to the PBGC.*—Making the controlled group liable for minimum funding contributions to ongoing plans.
4. *Unpaid employer contributions.*—Affording an employer's unpaid contributions to plans the status of a tax claim, improving its priority in bankruptcy proceedings.
5. *Distress criteria.*—The use of Chapter 11 (bankruptcy reorganization) as a criterion for termination was tightened. The employer was now required to show that liquidation would necessarily follow if the plan were not terminated.
6. *Additional payments to participants.*—Section 4049 of ERISA was repealed. The full employer liability now runs solely to the PBGC. The PBGC will pay participants and beneficiaries a portion of their outstanding benefit liabilities (i.e., unfunded benefit liabilities that are not guaranteed benefits) from the PBGC's employer liability recovery.

The Act included additional significant reforms, including revised minimum funding rules, a quarterly pension funding requirement, a strengthening of the PBGC's lien authority, a reduction of the number of times an employer may "waive," or decline to make, otherwise required plan contributions, and other modifications.

MULTIEMPLOYER PLAN INSURANCE PROGRAM

Coverage for multiemployer plans under ERISA was structured similarly to that of single-employer plans. However, the PBGC was not required to insure benefits of multiemployer plans that terminated before July 1, 1978. Congress extended the deadline for mandatory pension coverage several times, until enactment of the Multiemployer Pension Plan Amendments Act of 1980, or MPPAA (P.L. 96-364). MPPAA required better funding for multiemployer plans, especially those in financial distress. It also improved the ability of plans to collect contributions from employers. MPPAA changed the insurable event that triggers PBGC protection to plan insolvency, rather than plan termination. Thus, if a multiemployer plan becomes financially unable to pay benefits at the guaranteed level when due, the PBGC will provide financial assistance to the plan, in the form of a loan. And finally, MPPAA imposed withdrawal liability on employers who ceased to contribute to a multiemployer plan.

BUDGETARY TREATMENT

Since 1981, administrative expenses of the PBGC and the benefit payments to participants in plans under the PBGC's trusteeship have been counted as Federal outlays. But certain receipts of the agency—including premium payments, interest on balances in the revolving fund, and transfers to the revolving fund from the trust fund—offset PBGC expenses in the Federal budget. This "cash-flow" view of the PBGC does not take account, however, of liabilities for future benefit payments and other accruals. The net financial position of the PBGC, which does take into account obligations to pay future benefits, contrasts sharply with its status in the Federal budget, which uses more of a cash-flow basis for accounting. In each year between 1981 (when the program was first included in the Federal budget) and 1986, the effect of the PBGC has been to reduce overall Federal outlays (see table 4). During this period, the PBGC reported receipts in excess of benefit payments and administrative costs by a cumulative total of $240 million. In years before 1981, Federal accounts for the PBGC would also have shown annual inflows exceeding expenses in each year of program operation.

TABLE 4.—FEDERAL BUDGETARY TREATMENT OF THE PBGC, 1975-90

[In millions of dollars]

	Expenses [1]	Offsetting collections [2]	Outlays appearing in the Federal budget [3]
Not included in the Federal budget [4]			
Fiscal year:			
1975	3.2	35.5	NA
1976	12.8	28.5	NA
1977	21.0	41.0	NA
1978	47.6	61.9	NA
1979	52.3	91.5	NA
1980	59.1	90.1	NA
Total	196.0	348.5	NA

TABLE 4.—FEDERAL BUDGETARY TREATMENT OF THE PBGC, 1975–90—Continued

[In millions of dollars]

	Expenses [1]	Offsetting collections [2]	Outlays appearing in the Federal budget [3]
Included in the Federal budget [4]			
Fiscal year:			
1981	79.4	123.1	−29.0
1982	104.3	157.0	−66.9
1983	161.2	182.4	−9.5
1984	180.0	189.8	−9.9
1985	195.3	210.4	−19.1
1986	272.1	343.9	−105.9
1987	508.6	636.8	−71.9
1988	489.4	560.3	−277.7
1989	779.8	1,190.1	−149.1
1990	744.6	1,175.3	−679.9
Total	3,514.7	4,760.1	−1,418.9

[1] Includes primarily administrative costs and benefit payments.

[2] Includes primarily premium income, interest income, and transfers from the pension insurance trust fund to the revolving fund.

[3] Outlays do not equal the difference between expenses and offsetting collections because of changes in obligated program balances between the beginning and the end of the fiscal year.

[4] The PBGC was first included in the federal budget in 1981, in accordance with Public Law 96–364.

Source: Congressional Budget Office using data from the appendix to the Federal budget, various years.

Note: This table includes both the single-employer and multiemployer pension insurance programs. (NA = not applicable.)

FUTURE FINANCIAL STATUS OF THE PBGC

The future financial condition of the pension insurance program is highly uncertain because it will depend largely on how many private pension plans terminate and on the amount of underfunding in those plans. Both factors are hard to forecast accurately. It is estimated, however, that there is currently $20–$30 billion of underfunding in plans that the PBGC insures. Moreover, as was discussed above, a few pension plans with extremely large unfunded liabilities have dominated PBGC's past claims, and its future may likewise depend significantly on the fate of a few large plans, making liabilities even more difficult to predict. Future terminations will probably be influenced by overall economic conditions, by the prosperity of particular industries, by competition from abroad, and by a variety of factors that are specific to particular firms—such as their competitive position in the industry, their agreements with labor groups, and the assessments of their financial prospects that are necessary for them to obtain credit. In addition, PBGC's losses with respect to future terminations will depend on how well the new funding rules work, and on the PBGC's position in bankruptcy proceedings. Finally, pending litigation could have a material impact on the financial condition of the PBGC.

According to the President's 1992 budget, the Administration will propose legislation to clarify and improve the status of the PBGC's claims in bankruptcy, to revise the legal treatment of shutdown benefits, to give the PBGC the option of becoming a member of creditors' committees, and to further tighten the regulations for interest rates used to determine contributions to underfunded pensions.

The PBGC in its fiscal year 1990 annual report presented three different forecasts of future claims and resulting deficits and surpluses to indicate the potential variability of its financial condition. Forecast A is based on the average annual net claim over the entire PBGC history. Forecast B is based on the average annual net claim over the most recent 9 fiscal years, while forecast C, because of the potential for massive losses from the largest underfunded plans and other contingencies, assumes net claims of $900 million each year. Under forecast A, a surplus of $0.4 billion is achieved by the end of fiscal year 2000. Under the assumptions in forecast C, a deficit of $11.4 billion is projected at the end of fiscal year 2000.

TABLE 5.—YEAR BY YEAR PROJECTIONS OF PBGC DEFICITS UNDER VARIOUS FORECASTS, SINGLE-EMPLOYER PROGRAM [1]

[Amounts as of September 30]

	Dollars in billions		
	Forecast A	Forecast B	Forecast C
Fiscal year:			
1990	$1.9	$1.9	$1.9
1991	1.6	1.7	2.2
1992	1.4	1.6	2.7
1993	1.1	1.5	3.2
1994	.8	1.5	3.9
1995	.6	1.5	4.7
1996	.4	1.5	5.6
1997	.1	1.5	6.7
1998	(.1)	1.7	8.1
1999	(.2)	1.8	9.6
2000	(.4)	2.1	11.4

[1] PBGC's deficit equals the excess of guaranteed liabilities in plans assumed by the PBGC over the sum of assets in plans assumed by the PBGC, liabilities owed by employers to the PBGC, and the present value of expected premium income.

See text for a brief description of each forecast.

Note: ( ) = Surplus.

Source: PBGC.

APPENDIX G. DEMOGRAPHIC, ECONOMIC, AND SOCIAL CHARACTERISTICS OF FAMILIES WITH CHILDREN

INTRODUCTION

This appendix describes changes in the demographic, economic, and social characteristics of families with children. It covers a variety of topics related specifically to these families, including:

—the changing composition of families,
—the living arrangements of children,
—teenage pregnancy and child bearing,
—prenatal care,
—infant mortality,
—drug-addicted mothers and infants,
—child health,
—educational achievement,
—the labor force participation of women,
—child care,
—earnings and other income sources of families with children,
—child poverty,
—homelessness, and
—the impact of means-tested programs and Federal tax policy on the disposable income of female-headed families.

CHANGING FAMILY COMPOSITION

The number of one-parent families with children has increased rapidly over the past one and one-half decades. This trend is largely the result of higher divorce and lower remarriage rates and an increase in the number of never-married mothers. Between 1950 and 1981, the number of divorces increased from 385,000 to 1.2 million annually and the divorce rate more than doubled.[1] Since 1981, the number of divorces and the divorce rate have leveled but still remain high. In 1986, there were 1,178,000 divorces or a rate of 4.9 per 1,000 of the population. Provisional data for 1988 and 1989 suggest a slighly lower rate of 4.8 (table 1). Additionally, there has been a significant increase in the number of births to unmarried mothers. In 1988, one in four births in the United States was to an unmarried mother—up from only 1 in 20 births in 1960 (chart 1). More than three out of every five black births are to unmarried mothers.

---

[1] Bianchi, Suzanne M. "America's Children: Mixed Prospects," Population Bulletin, Vol. 45 (1), June 1990.

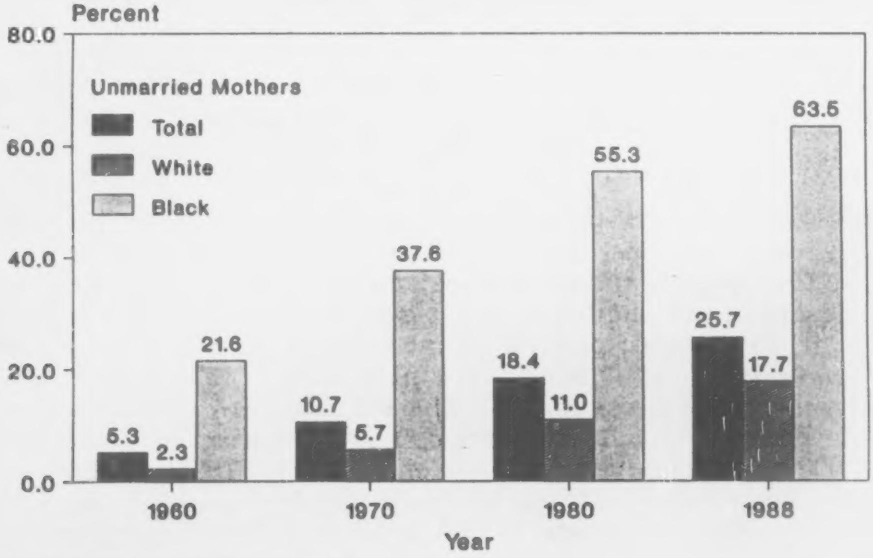
TABLE 1.—TOTAL NUMBER AND RATES OF MARRIAGES AND DIVORCES FOR SELECTED YEARS

	Number (thousands)		Rate [1]	
	Marriages	Divorces	Marriages	Divorces
1950	1,667	385	11.1	2.6
1960	1,523	393	8.5	2.2
1970	2,159	708	10.6	3.5
1980	2,390	1,189	10.6	5.2
1985	2,413	1,190	10.1	5.0
1986	2,407	1,178	10.0	4.9
1987	2,421	1,157	9.9	4.8
1988 (preliminary)	2,389	1,183	9.7	4.8

[1] Rate is per 1,000 of the population.

Source: National Center for Health Statistics, "Vital Statistics of the United States," annual and unpublished data.

CHART 1. PERCENTAGE OF BIRTHS TO UNMARRIED MOTHERS, BY RACE FOR SELECTED YEARS



Source: National Center for Health Statistics, published data

At the same time, the number of two-parent families with children has actually declined, due partly to lower marriage rates as individuals opt not to marry or opt to postpone marriage (Table 2). Between 1970 and 1990, the number of one-parent families increased 155.3 percent, growing from 3.8 to 9.7 million. Between 1970 and 1985, the number of two-parent families decreased 4.7 percent, falling from 25.8 to 24.6 million, but has since climbed back to 24.9 million.

TABLE 2.—TWO-PARENT AND ONE-PARENT FAMILIES AS PROPORTIONS OF ALL FAMILIES WITH CHILDREN PRESENT, BY RACE, FOR SELECTED YEARS

Subject	All races					White			Black		
	1970	1980	1985	1988	1990	1970	1988	1990	1970	1988	1990
	Number in thousands										
Total with children under 18	29,631	32,150	33,372	35,431	34,670	26,115	28,788	28,294	3,219	5,416	5,087
Two-parent family groups	25,823	25,231	24,573	24,600	24,921	23,477	21,699	21,905	2,071	2,016	2,006
One-parent family groups	3,808	6,920	8,779	10,224	9,749	2,638	6,582	6,389	1,148	3,339	3,081
Maintained by mother	3,415	6,230	7,737	8,940	8,398	2,330	5,544	5,310	1,063	3,136	2,860
Never married	248	1,063	2,208	2,707	2,775	73	1,050	1,139	173	1,605	1,572
Spouse absent	1,377	1,743	1,732	1,563	1,836	796	1,127	1,206	570	585	570
Separated	962	1,483	1,524	1,499	1,557	477	941	1,015	479	515	502
Divorced	1,109	2,721	3,228	3,121	3,194	930	2,568	2,553	172	471	574
Widowed	682	703	569	544	593	531	356	411	148	149	144
Maintained by father	393	692	1,042	1,284	1,351	307	1,037	1,079	85	204	221
	Percent distribution										
Total with children under 18	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Two-parent family groups	87.1	78.5	73.6	69.4	71.9	89.9	75.4	77.4	64.3	37.2	39.4
One-parent family groups	12.9	21.5	26.3	28.9	28.1	10.1	22.9	22.6	35.7	61.7	60.6
Maintained by mother	11.5	19.4	23.2	25.2	24.2	8.9	19.3	18.8	33.0	57.9	56.2
Never married	.8	3.3	6.6	7.6	8.0	.3	3.6	4.0	5.4	29.6	30.9
Spouse absent	4.6	5.4	5.2	4.4	5.3	3.0	3.9	4.3	17.7	10.8	11.2
Separated	3.2	4.6	4.6	4.2	4.5	1.8	3.3	3.6	14.9	9.5	9.9
Divorced	3.7	8.5	9.7	8.8	9.2	3.6	8.9	9.0	5.3	8.7	11.3
Widowed	2.3	2.2	1.7	1.5	1.7	2.0	1.2	1.5	4.6	2.8	2.8
Maintained by father	1.3	2.2	3.1	3.6	3.9	1.2	3.6	3.8	2.6	3.8	4.3

Note: Family groups consist of family households, related subfamilies, and unrelated subfamilies.

Source: U.S. Bureau of the Census, Current Population Reports, Series P–20, Household and Family Characteristics: March of Each Year. Washington, U.S. Govt. Print. Off.

As a result of these trends, the composition of families in the United States has changed. Whereas in 1970 two-parent families accounted for 87 percent of all families with children, in 1990 these families accounted for 71.9 percent of all families with children.

The decline in the incidence of two-parent families is especially pronounced among the black population. The proportion of white families maintained by two parents declined from 90 percent in 1970 to 77.4 percent in 1990, while the proportion of black families maintained by two parents declined from 64 percent in 1970 to 39.4 percent in 1990. One should note, however, that although the incidence of one-parent families is higher among blacks than whites, a majority of all one-parent families with children is white.

The majority of one-parent families is headed by a female. In 1990, 86.1 percent of all one-parent families with children were maintained by the mother, while 13.9 percent were maintained solely by the father. This percentage breakdown has changed only slightly since 1970.

The marital status of women who maintain one-parent families has changed dramatically over the period from 1970 to 1990. In 1970, only 7 percent of women maintaining families alone could be classified as having never been married, compared to 33 percent in 1990. Further, by 1990, a greater proportion of those women heading families who had ever married could be classified as having been divorced: in 1970, 35 percent of women in this group were divorced, compared with 57 percent in 1990.

LIVING ARRANGEMENTS OF CHILDREN

Tables 3 and 4 below describe trends in the living arrangements of children. The changing composition of families over the 1970 to 1989 period directly affected the living arrangements of children. Although the total number of children under the age of 18 in the United States declined from 69 to 64 million, the proportion of children affected by the divorce or separation of their parents, or the unmarried status of their mother, grew considerably. As a result, both the number and proportion of children living in one-parent families increased dramatically between 1960 and 1989. The number of children living with one parent grew 166 percent, from 5.8 to 15.5 million. Over 24 percent of all children lived in one-parent families in 1989, compared with 9 percent in 1960. These aggregate figures do not reveal the significant differences for black and white children. In 1989, 19 percent of all white children under age 18 and 55 percent of all black children under age 18 lived with one parent.

TABLE 3.—LIVING ARRANGEMENTS OF CHILDREN UNDER 18 YEARS: 1960, 1970, 1980, 1985, 1987, 1988, AND 1989

[Excludes persons under 18 years old who maintain households or family groups]

Living arrangements of children and marital status of parent	1960 by race		All races							1989 by race		
	White	Black [1]	1960	1970	1980	1985	1987	1988	1989	White	Black	Hispanic origin [2]
	Numbers in thousands											
Total number of children	55,077	8,650	63,727	69,162	63,427	62,475	62,932	63,179	63,637	51,134	9,835	6,973
Living with:												
Two parents	55,082	5,795	55,877	58,939	48,624	46,149	46,009	45,942	46,549	40,706	3,738	4,673
One parent	3,932	1,897	5,829	8,199	12,466	14,635	15,071	15,329	15,493	9,626	5,362	2,129
Mother only	3,381	1,723	5,105	7,451	11,406	13,081	13,420	13,521	13,700	8,220	5,023	1,940
Father only	551	173	724	748	1,060	1,554	1,651	1,808	1,793	1,406	339	189
Other relatives or nonrelatives only	1,062	959	2,021	2,024	2,337	1,691	1,852	1,908	1,595	802	735	171
	Percent distribution											
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Living with:												
Two parents	90.9	67.0	87.7	85.2	76.7	73.9	73.1	72.7	73.1	79.6	38.0	67.0
One parent	7.1	21.9	9.1	11.9	19.7	23.4	23.9	24.3	24.3	18.8	54.5	30.5
Mother only	6.1	19.9	8.0	10.8	18.0	20.9	21.3	21.4	21.5	16.1	51.1	27.8
Father only	1.0	2.0	1.1	1.1	1.7	2.5	2.6	2.9	2.8	2.7	3.4	2.7
Other relatives or nonrelatives only	1.9	11.1	3.2	2.9	3.7	2.7	2.9	3.0	2.5	1.6	7.5	2.5

TABLE 3.—LIVING ARRANGEMENTS OF CHILDREN UNDER 18 YEARS: 1960, 1970, 1980, 1985, 1987, 1988, AND 1989—Continued

[Excludes persons under 18 years old who maintain households or family groups]

Living arrangements of children and marital status of parent	1960 by race		All races							1989 by race		
	White	Black [1]	1960	1970	1980	1985	1987	1988	1989	White	Black	Hispanic origin [2]
						Numbers in thousands						
Total children living with one parent	3,932	1,897	5,829	8,199	12,466	14,635	15,071	15,329	15,493	9,626	5,362	2,129
Marital status of parent:												
Never married	61	182	243	557	1,820	3,756	4,295	4,673	4,791	1,815	2,848	678
Married, spouse absent	1,615	1,085	2,700	3,521	3,898	3,750	3,720	3,814	3,687	2,295	1,243	760
Separated	779	829	1,608	2,484	3,327	3,291	3,297	3,242	3,156	1,959	1,098	609
Widowed	1,139	405	1,543	1,649	1,469	1,101	916	970	985	677	245	106
Divorced	1,118	225	1,343	2,473	5,281	6,030	6,139	5,871	6,030	4,838	1,026	586
						Percent distribution						
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Marital status of parent:												
Never married	1.6	9.6	4.2	6.8	14.6	25.7	28.5	30.5	30.9	18.9	53.1	31.8
Married, spouse absent	41.1	57.2	46.3	42.9	31.3	25.6	24.7	24.9	23.8	23.8	23.2	35.7
Separated	19.8	43.7	27.6	30.3	26.7	22.5	21.9	21.1	20.4	20.4	20.5	28.6
Widowed	29.0	21.3	26.5	20.1	11.8	7.5	6.1	6.3	6.4	7.0	4.6	5.0
Divorced	28.4	11.9	23.0	30.2	42.4	41.2	40.7	38.3	38.9	50.3	19.1	27.5

[1] Nonwhite for 1960.

[2] Persons of Hispanic origin may be of any race.

Source: U.S. Bureau of the Census. Current Population Reports, Series P–20. Marital Status and Living Arrangements: March of Each Year. Washington, U.S. Govt. Printing Off.

TABLE 4.—STATUS OF CHILDREN: 1960–1989

[In thousands]

	1960	1970	1975	1980	1985	1987	1988	1989
Children under 18:								
Total in population	63,727	69,162	64,165	63,427	62,475	62,932	63,179	63,637
Living with 1 parent	5,829	8,199	11,245	12,466	14,635	15,071	15,329	15,493
As percent of all children	9.1	11.9	17.5	19.7	23.4	23.9	24.3	24.3
Living with never-married parent	243	557	1,198	1,820	3,756	4,295	4,673	4,791
As percent of all children	.4	.8	1.9	2.9	6.0	6.8	7.4	7.5
Receiving AFDC	[1] 2,314	6,104	7,952	7,295	7,074	7,240	7,328	7,370

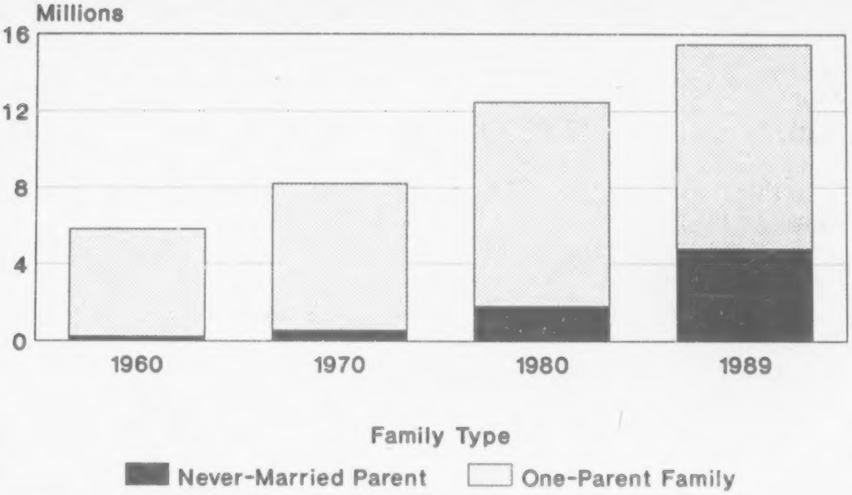
[1] Includes some children ages 18 to 22.

Source: Based on Census and DHHS publications.

In both 1970 and 1989, the majority of children in one-parent families lived with a mother rather than a father, and the percentage breakdown changed only slightly during this period. Of children living with one parent, 90.9 percent lived with their mother in 1970, compared with 88.4 percent in 1989. Between 1970 and 1989, the number of children living with only a father grew from 0.7 million to 1.8 million.

As one would expect from the data presented in the previous subsection, a greater proportion of children in one-parent families lived with a divorced or never-married parent in 1989 compared with 1970. In 1989, 38.9 percent of children in one-parent families lived with a divorced parent; 30.9 percent lived with a parent who had never been married, representing nearly 5 times the 1970 percentage. Chart 2 highlights the growing number of one-parent families from 1960 to 1989, including those children living with never-married parents.

CHART 2. NUMBER OF CHILDREN IN SINGLE-PARENT FAMILIES INCLUDING THOSE FAMILIES NEVER-MARRIED, SELECTED YEARS

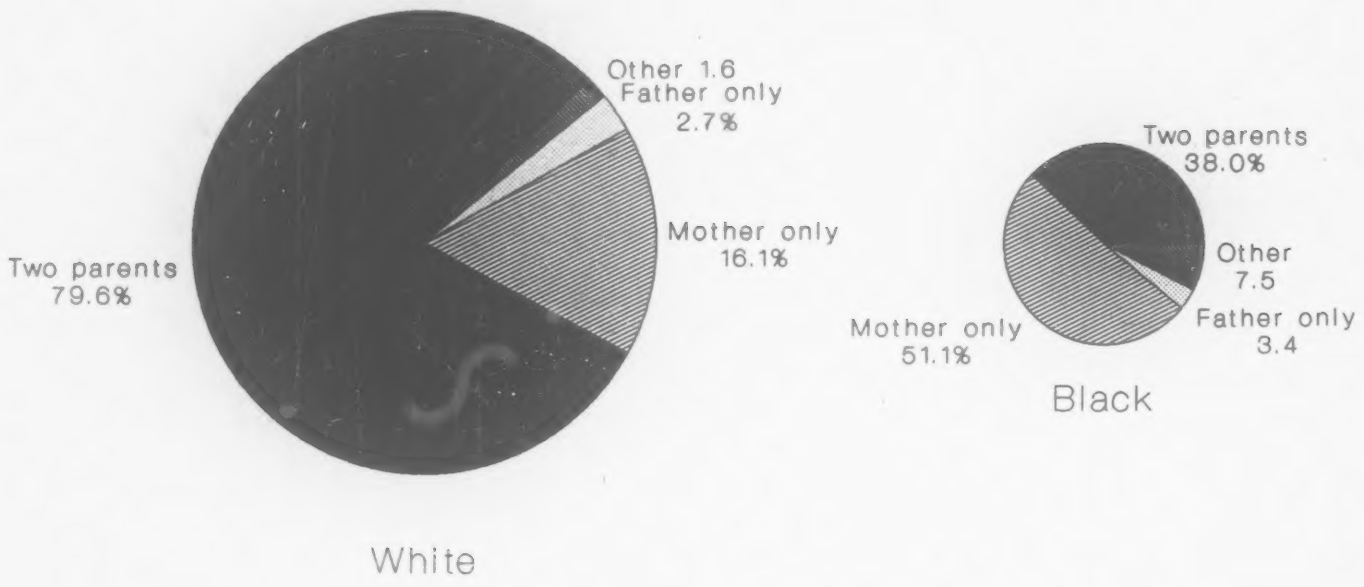


Note: One-parent families include all never-married parents

Source: Based on Census and DHHS publications.

The most notable changes in the living arrangements of children are seen in the increasing differences between white and minority children. The proportion of white children living with two parents declined by 12 percentage points between 1960 and 1988, but declined by 28 percentage points for blacks. In 1988, almost four in five white children lived in two-parent families compared with about two in five black children (chart 3).

CHART 3. LIVING ARRANGEMENTS OF BLACK AND WHITE CHILDREN, 1988



SOURCE: Based on data from the U.S. Bureau of the Census. Current Population Reports, Series P–20. Married Status and Living Arrangements: March 1990.

Black children are also much more likely to live with a never-married mother (see chart 1). In 1987, 62 percent of black babies in the United States were born to unmarried mothers compared with 17 percent of white babies born that year. Between 1960 and 1988, the proportion of white children living with a never-married single parent also grew from less than 2 percent to 18 percent, due in large part to an overall increase in single parents who have never married.[2]

The data presented above gives a snapshot of the living arrangements of children at a given point in time. However, a snapshot approach can be misleading for several reasons, three of which are described here.[3] [4] One, snapshot data understate the number of children who will spend at least some time in a single-parent home. Based on current trends, it is estimated that 70 percent of white children and 94 percent of black children born in 1980 will spend part of their childhood in a single-parent home before the age of 18. These lifetime prevalence data present a much different view than do the snapshot data. Two, in one respect the snapshot approach overstates differences between blacks and whites. On average, blacks become mothers at an earlier age and are also less likely to marry or remarry than whites. As a result, snapshot data are closer to lifetime prevalance data for blacks than for whites. Although the snapshot data illustrate that the proportion of children living in a single-parent home is almost three times greater for blacks than whites, the lifetime prevalence data is only 35 percent higher for blacks than it is for whites. Three, the snapshot approach does not give any indication of the length of time that children tend to spend in a single-parent home. The length of time spent in a single-parent home is much higher for black children since their mothers tend to have lower marriage and remarriage rates. It is estimated that black children born in 1980 will on average spend 59 percent of their childhood in a single-parent family; white children born in 1980 can expect to spend, on average, 31 percent of their childhood in a single-parent family.

CHANGING NUMBERS OF CHILDREN [5]

During 1940, approximately 2.6 million babies were born in the United States. Following World War II, the "baby boom" generation began with births jumping to 3.6 million by 1950 and peaking at about 4.3 million in the early 1960s, two-thirds higher than the number of births in 1940. From that point, the number of births started to spiral downward, bottoming out at 3.1 million in 1975. Even at this low point, the number of births was 23 percent higher than in 1940.

---

[2] Bianchi, Suzanne M. "America's Children: Mixed prospects," Population Bulletin, Vol. 45, No. 1, June 1990.

[3] The discussion in this paragraph is from "Single Mothers and Their Children," by Irwin Garfinkel and Sara S. McLanahan, The Urban Institute, 1986.

[4] Data are based on the PSID, and are found in "Updating Chidren's Life Course" by Sandra Hofferth, "Journal of Marriage and Family," February 1985.

[5] This section borrows heavily from Bianchi, Suzanne M. "America's Children: Mixed Prospects," Population Bulletin, Vol. 45 (1), June 1990.

The National Center for Health Statistics reports 3.8 million births for 1987, 3.9 million in 1988, and provisional data for 1989 suggest that the number of births exceeded 4 million for the first time since the baby boom (table 5). In terms of the child population, the number of children under the age of 5 increased 11 percent between 1980 and 1988 and is projected to peak around 1990 and then decline by 2000. Additionally, the ratio of children to the population of working age has slipped from a high to 66 per 100 in 1965 to 42 per 100 in 1988, and is expected to decline even further.

TABLE 5.—BIRTHS AND BIRTH RATES, BY RACE OF CHILD, SELECTED YEARS

Year	Total births				Birth rate [1]			
	All races	White	All other		All races	White	All other	
			Total	Black			Total	Black
1940	2,559,000	2,199,000	360,000	....	19.4	18.6	26.7	....
1950	3,632,000	3,108,000	524,000	....	24.1	23.0	33.3	....
1960	4,257,850	3,600,744	657,106	602,264	23.7	22.7	32.1	
1970	3,731,386	3,091,264	640,122	572,362	18.4	17.4	25.1	31.9
1975	3,144,198	2,551,996	592,202	511,581	14.6	13.6	21.0	25.3
1980	3,612,258	2,898,732	713,526	589,616	15.9	14.9	22.5	20.7
1985	3,760,561	2,991,373	769,188	608,193	15.8	14.8	21.4	22.1
1986	3,756,547	2,970,439	786,108	621,221	15.6	14.5	21.4	21.1
1987	3,809,394	2,992,488	816,906	641,567	15.7	14.5	21.7	21.2
1988	3,909,510	3,046,162	863,348	671,976	15.9	14.7	22.5	21.6
								22.2

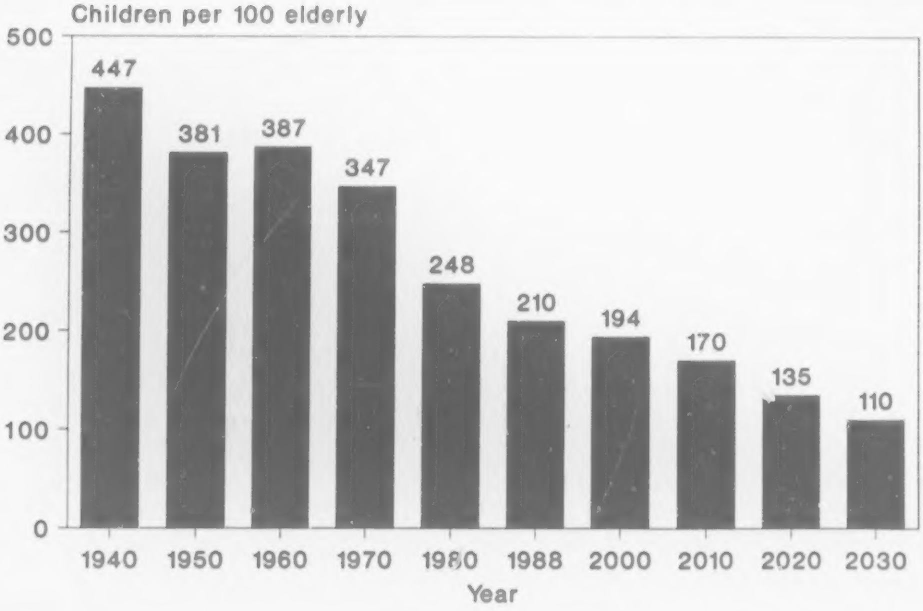
[1] The birth rate is defined as the number of births per 1,000 of the population.

Source: National Center for Health Statistics. Advance report of final natality statistics, 1988. Monthly Vital Statistics Report, Vol. 39, No. 4 Suppl. DHHS, Hyattsville, MD, 1990.

The ratio of children to the elderly has dropped even more dramatically. In 1940, when mortality at older ages was high by today's standards, there were 447 children under age 18 for every 100 persons over age 65. This ratio has declined steadily, although in 1988, children still outnumbered the elderly by more than two to one. By the year 2030, with the older population continuing to grow faster than the younger population, there will be nearly equal numbers of American children and elderly (see chart 4).

CHART 4. RATIO OF CHILDREN TO ELDERLY, 1940–1988, AND PROJECTIONS TO 2030

Children < 18 per 100 persons age 65+



Source: Data from Bianchi, Suzanne M. "America's Children: Mixed Prospects," Population Bulletin, Vol. 45 (1), June 1990.

STATISTICAL TRENDS IN TEENAGE PREGNANCY [6]

Sexual activity

Researchers have used various national surveys to calculate estimates of never-married teenagers who have ever had sexual intercourse. During the 1970's, the proportion of young unmarried women having sexual intercourse during their teen years increased dramatically among whites as well as blacks. Between 1982 and 1988, the proportion of white teen females having sexual intercourse continued to increase, while the incidence of such activity among black females was more variable (table 6). By the late

---

[6] The sections on teen sexual activity borrow heavily from "U.S. Children and Their Families: Current Conditions and Recent Trends, 1989," a report of the Select Committee on Children, Youth, and Families, September, 1989.

1980's, the substantial race differences with respect to sexual experience found in the 1970's seemed to have narrowed. During the teen years, the proportion of women experiencing sexual activity increases substantially with age. In 1988, about one in four females aged 15 and four out of five females aged 19 had experienced sexual intercourse at least once.

TABLE 6.—PERCENT OF FEMALE TEENAGERS WHO HAVE EVER EXPERIENCED SEXUAL INTERCOURSE BY RACE AND AGE, 1971–88

	Never married teens			Never married and married teens	
	1971	1976	1982	1982	1988
Whites					
Age:					
15	11	14	17	18	29
16	17	23	27	29	32
17	22	36	36	40	46
18	32	44	50	55	67
19	39	49	63	69	81
Blacks					
15	31	38	28	28	26
16	46	53	41	42	46
17	59	68	55	55	69
18	63	74	76	77	69
19	76	84	81	82	81

Note: Data on never-married teens only are not yet available for 1988. Because of rapid changes in marriage patterns among teens during this time period, differences in sample definitions can affect conclusions about trends. Comparisons can safely be made only for never-married females between 1971 and 1982 and for females both married and unmarried between 1982 and 1988.

Source: Zelnik, Melvin, and John F. Kantner, "Sexual and Contraceptive Experience of Young Unmarried Women in the United States, 1976 and 1971," Family Planning Perspectives, Vol. 9, No. 2, March/April 1977, Table 1. National Center for Health Statistics, Pratt, William F., William D. Mosher, Christine A. Bachrach, and Marjorie C. Horn, "Understanding U.S. Fertility: Finding from the National Survey of Family Growth, Cycle III," Population Bulletin, Vol. 39, No. 5, December 1984, Table 2. National Center for Health Statistics, London, K.A., W.D. Mosher, W.F. Pratt, and L.B. Williams, "Preliminary Findings from the National Survey of Family Growth, Cycle IV," March 1989.

TABLE 7.—PERCENTAGE OF WOMEN AGED 15–19 WHO HAD EVER HAD SEXUAL INTERCOURSE BY RACE/ETHNICITY AND POVERTY LEVEL, ACCORDING TO AGE GROUP, 1982 AND 1988

Race/ethnicity and poverty level	15–19		15–17		18–19	
	1982	1988	1982	1988	1982	1988
Total	47.1	53.2	32.6	38.4	64.1	74.4
Race/ethnicity:						
Non-Hispanic white	44.5	52.4	29.8	36.2	60.8	74.3
Non-Hispanic black	59.0	60.8	44.4	50.5	79.1	78.0
Hispanic	50.6	48.5	35.6	36.1	70.1	70.0
Poverty level:						
Below 200%	55.6	56.5	45.7	41.6	65.0	80.9
Above or equal to 200%	39.7	50.1	23.0	35.0	63.0	69.0

Source: Forrest, Jacqueline Darroch and Susheela Singh, "The Sexual and Reproductive Behavior of American Women, 1982–1988," Family Planning Perspectives, 22(5), September/October, 1990.

Table 7 reveals that the increase in the proportion of teenagers who had ever had intercourse was primarily attributable to increases among white and non-poor teenagers.[7] Overall, there was only a small increase in the proportion of non-Hispanic black teenagers ages 15 to 19 who had had sex, but there was an 18 percent increase among non-Hispanic whites (from 45 to 52 percent). Teenagers living in families with incomes below 200 percent of the poverty level reported little change in their level of sexual experience, whereas teenagers with higher family incomes experienced a 25 percent increase (from 40 percent in 1982 to 50 percent in 1988). As a result of these changes, the differentials in sexual experience between white and black teenagers and between those from more and less affluent families had greatly narrowed by 1988.

Between 1979 and 1988, the proportion of never-married males aged 17 to 19 reporting sexual intercourse at least once rose from two-thirds to three-fourths (table 8). In both years, higher proportions of black than white males reported sexual experience. Contraceptive use similarly rose. The use of condoms more than doubled between these years, while the proportion using "no method" declined from one-half to one-fifth.

---

[7] Forrest, Jacqueline Darroch and Susheela Singh, "The Sexual and Reproductive Behavior of American Women, 1982–1988," Family Planning Perspectives, 22(5), September/October 1990.

TABLE 8.—PERCENT OF MALE TEENAGERS WHO HAVE EVER EXPERIENCED SEXUAL INTERCOURSE, AND REPORTED CONTRACEPTIVE USE, BY AGE AND RACE, 1979–88

	All races		Blacks		Nonblacks	
	1979	1988	1979	1988	1979	1988
Age:						
17 to 19	66	76	71	88	65	73
17	56	72	60	90	55	68
18	66	71	80	80	64	69
19	78	88	80	98	77	86
Contraceptive method used last time had sexual intercourse (percent distribution):						
Condoms	21	58	23	62	21	57
Effective female method, but not condoms	28	22	27	19	28	22
No method or ineffective method	51	21	50	19	51	21

Note: Samples were restricted to teenagers living in metropolitan areas of the U.S. "Effective" female methods of contraception including oral contraceptives, diaphragm, IUD, or spermicidal sponge, foam, jelly, or suppository.

Source: National Survey of Young Men; Sonenstein, Freya, Joseph Pleck, and Leighton Ku, "At Risk of AIDS," March, 1989, table 5; Zelnik, M. and J. Kantner, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan-Area Teenagers: 1971–1979," Family Planning Perspectives, 12(5), September/October, 1980.

Selected data on teenage pregnancy [8]

Table 9 contains the numbers and rates of births, legal abortions and pregnancies for teenagers under the age of 20 for 1972 through 1985, according to age at pregnancy outcome. There have been over 1 million teenage pregnancies each year since 1973, with a total of 1,031,040 adolescent pregnancies in 1985. Almost 31,000 of the total number of teenage pregnancies were to women under age 15. Of the teenage pregnancies, 477,705 (46 percent) resulted in live births, 416,170 (40 percent) in induced abortions, and the remainder in miscarriages or stillbirths.

The pregnancy rate for women ages 15 to 19 (chart 5 and table 9) rose from 95.1 births per 1,000 women in 1972 to a high of 111.2 in 1980, and remained fairly stable for the next 5 years with a rate of 109.8 in 1985. The birth rate for the same group dropped fairly sharply between 1972 and 1978, from 61.7 to 51.5 births per 1,000 women, increased slightly to 53.3 in 1980 and then fell back to 51.3 in 1985. Abortion rates, in contrast, rose during the 1970s from 19.1 to 42.9 in 1980, and then remained almost stable, with only a slight increase to 43.8 in 1985.

Compared with those of other Western industrialized countries, the U.S. teenage birth rate is the highest outside Eastern Europe, and the teenage abortion and pregnancy rates are the highest of any country publishing accurate abortion statistics (charts 6 and 7).

---

[8] This section borrows heavily from National Center for Health Statistics, "Final Natality Statistics, 1990."

Part of the differential in the adolescent childbearing rates is due to the higher rates of poverty in the United States. An additional cause for the differential is due to inadequacies in the family planning system—for example, it is more difficult for teenagers and the poor to receive contraceptives in the United States than in many other countries.[9] Chart 6 shows the birth, abortion, and pregnancy rates per 1,000 women ages 15 to 19 for 11 countries. Except for Czechoslovakia and Hungary, the countries shown have birth rates ranging from slightly more than one-half (New Zealand) to less than one-sixth (the Netherlands) of the U.S. rate. Furthermore, the Alan Guttmacher Institute reports that the adolescent birth rates have been declining more rapidly in most other developed countries than in the United States.

TABLE 9.—NUMBERS AND RATES OF BIRTHS, ABORTIONS, AND PREGNANCIES, BY AGE AT PREGNANCY OUTCOME, ACCORDING TO YEAR, 1972–85

Year	Female population (thousands)	Total number				Rate		
		Births	Legal abortions	Estimated miscarriages [1]	Pregnancies [2]	Birth	Abortion	Pregnancy
Women under age 15: [3]								
1985	1,858	10,220	16,970	3,740	30,930	5.5	9.1	16.6
1984	1,823	9,965	16,920	3,690	30,570	5.5	9.3	16.8
1983	1,786	9,752	16,350	3,590	29,690	5.5	9.2	16.6
1982	1,748	9,773	14,590	3,410	27,770	5.6	8.3	15.9
1981	1,781	9,632	15,240	3,450	28,320	5.4	8.6	15.9
1980	1,834	10,169	15,340	3,570	29,080	5.5	8.4	15.9
1979	1,944	10,699	16,220	3,760	30,680	5.5	8.3	15.8
1978	2,020	10,772	15,110	3,670	29,550	5.3	7.5	14.6
1977	2,048	11,455	15,650	3,860	30,970	5.6	7.6	15.1
1976	2,080	11,928	15,820	3,960	31,710	5.7	7.6	15.2
1975	2,118	12,642	15,260	4,050	31,950	6.0	7.2	15.1
1974	2,086	12,529	13,420	3,850	29,800	6.0	6.4	14.3
1973	2,094	12,861	11,630	3,740	28,230	6.1	5.6	13.5
1972	2,093	12,082	NA	NA	NA	5.8	NA	NA
Women ages 15 to 17:								
1985	5,397	167,789	165,630	50,120	383,540	31.1	30.7	71.1
1984	5,362	166,744	160,900	49,440	377,080	31.1	30.0	70.3
1983	5,400	172,673	166,440	51,180	390,290	32.0	30.8	72.3
1982	5,598	181,162	168,410	53,070	402,640	32.4	30.1	71.9
1981	5,848	187,397	175,930	55,070	418,400	32.0	30.1	71.5
1980	6,075	198,222	183,350	57,980	439,550	32.6	30.2	72.4
1979	6,200	200,137	178,570	57,880	436,590	32.3	28.8	70.4
1978	6,286	202,661	169,270	57,460	429,390	32.2	26.9	68.3
1977	6,310	213,788	165,610	59,320	438,720	33.9	26.2	69.5
1976	6,319	215,493	152,700	58,370	426,560	34.1	24.2	67.5
1975	6,288	227,284	(151,630)**	60,620	439,530	36.1	24.1	69.9
1974	6,276	234,194	(139,850)**	60,820	434,860	37.3	22.3	69.3
1973	6,185	238,403	(115,950)**	59,280	413,630	38.5	18.7	66.9
1972	6,071	236,641	(95,500)**	56,880	389,020	39.0	15.7	64.1

---

[9] Danzinger, Sheldon and Jonathan Stein, "The Causes and Consequences of Child Poverty in the United States," prepared for UNICEF, March 1990.

TABLE 9.—NUMBERS AND RATES OF BIRTHS, ABORTIONS, AND PREGNANCIES, BY AGE AT PREGNANCY OUTCOME, ACCORDING TO YEAR, 1972–85—Continued

Year	Female population (thousands)	Total number				Rate		
		Births	Legal abortions	Estimated miscarriages[1]	Pregnancies[2]	Birth	Abortion	Pregnancy
Women ages 18 to 19:								
1985	3,710	299,696	233,570	83,300	616,570	80.8	63.0	166.2
1984	3,869	302,938	237,970	84,380	625,290	78.3	61.5	161.6
1983	4,056	316,613	244,890	87,810	649,310	78.1	60.4	160.1
1982	4,169	332,596	250,330	91,550	674,480	79.8	60.0	161.8
1981	4,163	339,995	257,400	93,740	691,140	81.7	61.8	166.0
1980	4,284	353,939	261,430	96,930	712,300	82.6	61.0	166.3
1979	4,297	349,335	266,030	96,470	711,840	81.3	61.9	165.7
1978	4,269	340,746	249,520	93,100	683,370	79.8	58.4	160.1
1977	4,271	345,366	231,020	92,180	668,570	80.9	54.1	156.5
1976	4,263	343,251	209,980	89,650	642,880	80.5	49.3	150.8
1975	4,178	354,968	(175,150)**	88,510	618,630	85.0	41.9	148.1
1974	4,074	361,272	(139,850)**	86,240	587,360	88.7	34.3	144.2
1973	4,008	365,693	(115,950)**	84,730	566,370	91.2	28.9	141.3
1972	3,917	379,639	(95,500)**	85,480	560,620	96.9	24.4	143.1
Women ages 15 to 19:								
1985	9,106	467,485	399,200	133,420	1,000,110	51.3	43.8	109.8
1984	9,231	469,682	398,870	133,820	1,002,370	50.9	43.2	108.6
1983	9,456	489,286	411,330	138,990	1,039,610	51.7	43.5	109.9
1982	9,767	513,758	418,740	144,630	1,077,130	52.6	42.9	110.3
1981	10,010	527,392	433,330	148,810	1,109,530	52.7	43.3	110.8
1980	10,360	552,161	444,780	154,910	1,151,850	53.3	42.9	111.2
1979	10,498	549,472	444,600	154,350	1,148,420	52.3	42.4	109.4
1978	10,555	543,407	418,790	150,560	1,112,760	51.5	39.7	105.4
1977	10,581	559,154	396,630	151,490	1,107,270	52.8	37.5	104.6
1976	10,582	558,744	362,680	148,020	1,069,440	52.8	34.3	101.1
1975	10,465	582,252	324,930	148,940	1,056,120	55.6	31.0	100.9
1974	10,349	595,466	278,280	146,920	1,020,670	57.5	26.9	98.6
1973	10,193	604,096	232,440	144,060	980,600	59.3	22.8	96.2
1972	9,988	616,280	(191,000)**	142,360	949,640	61.7	19.1	95.1

[1] Estimated as 20 percent of births and 10 percent of abortions.

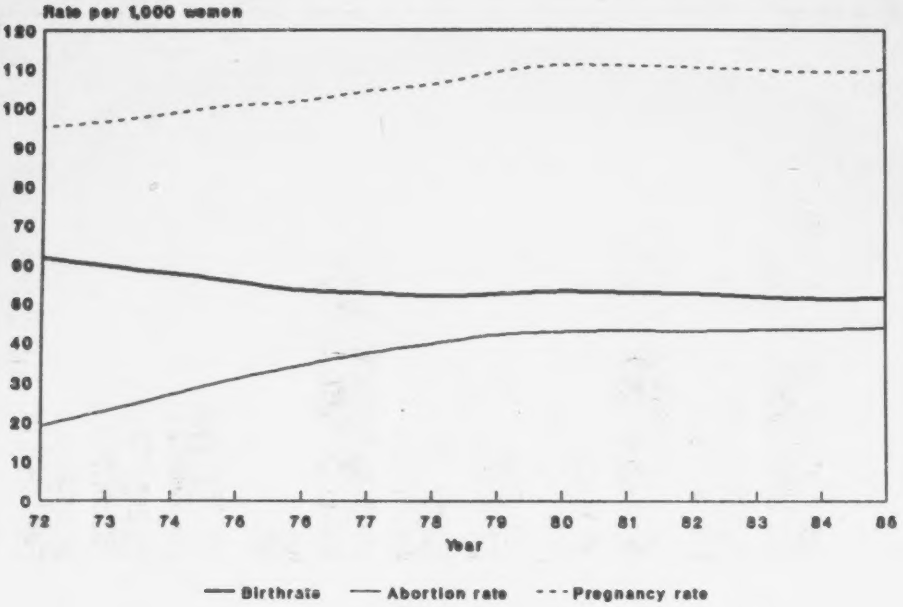
[2] Sum of births, abortions and miscarriages.

[3] Population is women aged 14.

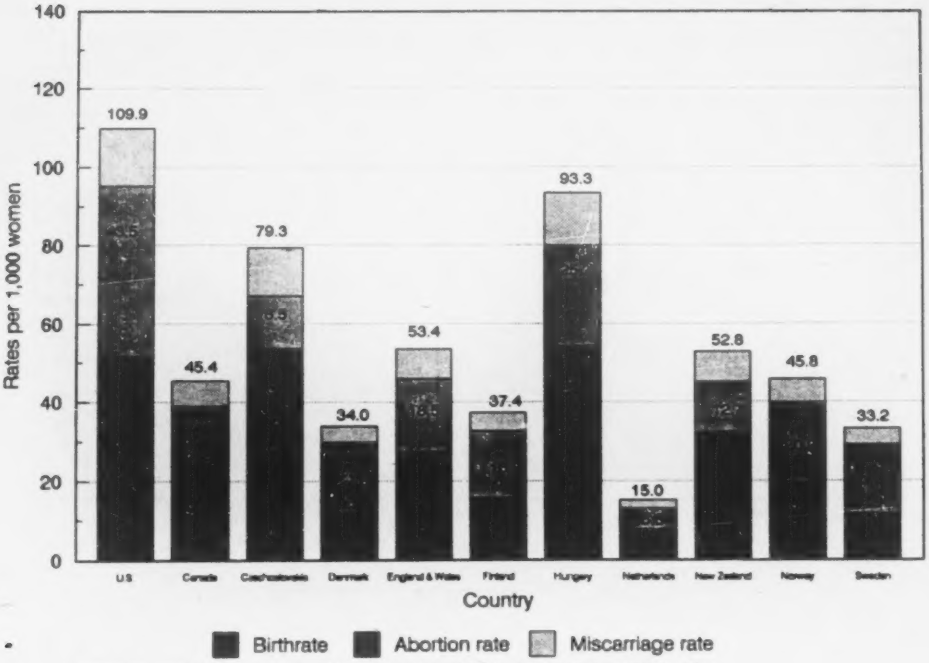
** Estimated from partial data.

Note: NA = data not available.

Source: Data primarily from U.S. Bureau of the Census; National Center for Health Statistics, "Final Natality Statistics," and the Centers for Disease Control. In Henshaw, S., Kenney, A., Somberg, D., and Ven Vort, J., "Teenage Pregnancy in the United States: The Scope of the Problem and State Responses." The Alan Guttmacher Institute, 1989. Tables 4–5.

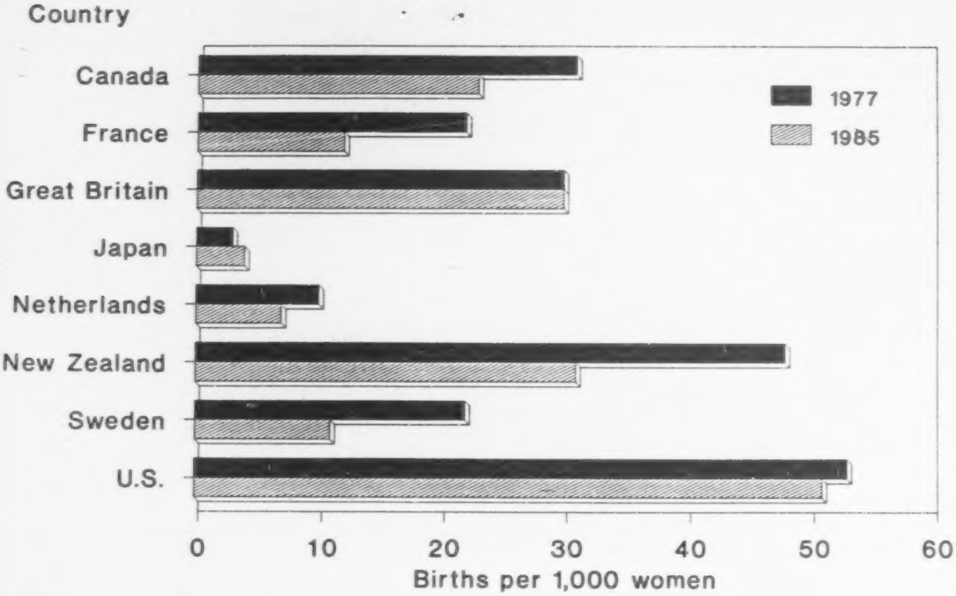


SOURCE: Henshaw, S., Kenney, A., Somberg, D., and Van Vort, J., "Teenage Pregnancy in the United States: The Scope of the Problem and State Responses." Washington, DC: The Alan Guttmacher Institute, 1989



Sources: Numbers of Abortions-C. Tietze and S.K. Henshaw, Induced Abortion A World Review, 1986 6th edition, The Alan Gutmacher Institute, New York, 1986. Birth-population estimates were obtained from the statistical offices of the countries.

CHART 7. BIRTH RATES FOR WOMEN AGED 15–19 FOR SELECTED COUNTRIES, 1977 AND 1985 (NUMBER OF BIRTHS PER 1,000 WOMEN)



Trends in teenage birth rates

Table 10 details birth rate trends and racial differences in birth rates of young women. Between the early 1960's and 1976, the birth rates of both white and black women ages 15 to 19 declined significantly. As table 10 shows, the birth rate of white women ages 15 to 19 fell from 79.4 (births per 1,000 women in the age group) in 1960 to 44.1 in 1976, representing an average annual decline in the birth rate of 3.6 percent. The birth rate of black women ages 15 to 19 fell from 147.6 in 1964 (the earliest year for which data are available) to 104.9 in 1976, representing an average annual decline of 2.8 percent (the birth rate of white women declined at an average annual rate of 3 percent over this same 1964 to 1976 period).

Although the birth rates of both blacks and whites ages 15 to 19 continued to decline after 1976, the decline was considerably slower than it was over the 1960 to 1976 period, and slower for whites than for blacks. The birth rate of young white women fell from 44.1 in 1976 to 41.9 in 1987. The birth rate of black women fell from 104.9 in 1976 to 100.3 in 1987.

However, despite recent declines, 1988 saw significant increases in the teenage birth rate from 1987 levels, particularly for those teens ages 15 to 17. The birth rate for all teens ages 15 to 17 rose 5.8 percent (76.6) for whites and 5.1 percent (25.5) for blacks with an overall increase of 5.9 percent (33.8) for all races. The 1988 rate of 33.8 was higher than in any year since 1977 (33.9). Black teens ages 18 to 19 also faced an increase of 5.8 percent (150.5), the highest rate since 1975 (152.4).

The National Center for Health Statistics reports that it is not possible to account for the recent rise in rates for young teens from birth certificate data, but data from the 1988 National Survey of Family Growth show that the proportion of young teens who are sexually experienced has increased considerably in recent years.

The total number of births to unmarried teenagers was 322,406 for 1988 (table 11). This is a 7-percent increase from the 1987 total (302,541). The nonmarital births represent 66 percent of all teenage births (490,000) for 1988. The rate for unmarried teens ages 15 to 19 rose to 36.8 in 1988, 7.9 percent higher than in 1987 (34.1) and 33.3 percent higher than in 1980 (27.6).

The rate for nonmarital childbirth increased for both white and black adolescents, continuing a trend that has been observed for more than a decade (table 12). The unmarried birth rates for black teenagers ages 15 to 17 and 18 to 19 reached their highest points since 1977 and 1971 respectively. For white teens, the birth rates have continued to rise, reaching their highest levels ever.

During this period of rapid increase in nonmarital childbearing, childbearing by married adolescents has declined, according to the National Center for Health Statistics. Because the trends in marital and nonmarital childbearing have diverged in the 1980s, the proportion of all births to unmarried adolescents has risen sharply.

TABLE 10.—NUMBER OF BIRTHS AND BIRTH RATES TO WOMEN AGES 15 TO 19, 1960 TO 1988

Year	Number of births, all women under 20		Birth rate [1]					
			All women 15 to 19		15 to 17		18 to 19	
	White	Black	White	Black	White	Black	White	Black
1960			79.4					
1961			79.2					
1962			73.2					
1963			68.2					
1964			63.4	147.6				
1965			60.6	144.6				
1966			60.4	142.7	26.6	97.9	108.2	219.2
1967			56.9	141.8	25.7	99.5	104.0	213.4
1968			54.9	138.7	25.6	98.2	100.5	206.1
1969	437,958	168,588	54.7	137.0	26.4	96.9	99.2	202.5
1970	467,928	179,100	57.4	147.7	29.2	101.4	101.5	204.9
1971	450,856	178,948	53.6	134.5	28.5	99.4	92.3	192.6
1972	438,559	179,712	51.0	129.8	29.3	99.5	84.3	179.5
1973	429,570	176,551	49.0	123.1	29.2	96.0	79.3	166.6
1974	425,205	171,721	47.9	116.5	28.7	90.0	77.3	158.7
1975	415,202	168,359	46.4	111.8	28.0	85.6	74.0	152.4
1976	389,329	160,597	44.1	104.9	26.3	80.3	70.2	142.5
1977	396,854	161,772	44.1	104.7	26.1	79.6	70.5	142.9

TABLE 10.—NUMBER OF BIRTHS AND BIRTH RATES TO WOMEN AGES 15 TO 19, 1960 TO 1988—Continued

Year	Number of births, all women under 20		Birth rate [1]					
			All women 15 to 19		15 to 17		18 to 19	
	White	Black	White	Black	White	Black	White	Black
1978	384,572	157,069	42.9	100.9	24.9	75.0	69.4	139.7
1979	388,209	158,944	43.7	101.7	24.7	75.7	71.0	140.4
1980	392,229	156,146	44.7	100.0	25.2	73.6	72.1	138.8
1981	373,983	148,703	44.6	97.1	25.1	70.6	71.9	135.9
1982	362,101	145,929	44.6	97.0	25.2	71.2	70.8	133.3
1983	342,183	142,105	43.6	95.5	24.8	70.1	68.3	130.4
1984	320,953	134,392	42.5	95.7	23.9	69.7	68.1	132.0
1985	322,826	140,130	42.8	97.4	24.0	69.8	70.1	137.1
1986	315,335	141,806	41.8	98.1	23.4	70.0	69.8	141.0
1987	312,108	144,853	41.9	100.3	24.1	72.9	68.6	142.2
1988	319,544	152,508	43.7	105.9	25.5	76.6	69.2	150.5

[1] Births per 1,000 women in the age group.

Sources: U.S. National Center for Health Statistics. Vital Statistics of the United States, 1979: Natality. Table 1-6. U.S.C. National Center for Health Statistics. Monthly Vital Statistics Report: Advance Report of Final Natality Statistics. 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, and 1990, tables 2 and 4.

TABLE 11.—NUMBERS AND RATES OF BIRTHS TO UNMARRIED WOMEN, BY AGE OF MOTHER AND RACE OF CHILD, 1988

Age	Number				Rate			
	All races	White	All other		All races	White	All other	
			Total [1]	Black			Total [1]	Black
Under 15	9,907	3,522	6,385	6,111				
15 to 19	312,499	168,641	143,858	133,419	36.8	24.8	98.3	85.9
15 to 17	136,137	70,501	65,636	61,299	26.5	17.1	74.1	64.1
18 to 19	176,362	98,140	78,222	72,120	52.7	36.4	136.1	120.3
Under 20	322,406	172,163	150,243	139,530				
20 to 24	350,905	186,598	164,307	151,308	56.7	38.3	138.2	124.3

[1] Includes blacks.

Source: National Center for Health Statistics, Vital Statistics of the United States, Vol. 39, No. 4, Supplement, August 15, 1990, Natality, Table 18.

TABLE 12.—ESTIMATED BIRTH RATES FOR MARRIED AND UNMARRIED WOMEN AGES 15–19, BY RACE: 1966 TO 1988

[Births per 1,000 women]

Year	Marital status, race, and age					
	Married		Unmarried			
	White, 15 to 19	Black, 15 to 19	White		Black	
			15 to 17	18 to 19	15 to 17	18 to 19
1966	438.8		5.4	14.1		
1967	424.1		5.6	15.3		
1968	422.0		6.2	16.6		
1969	423.1	514.6	6.6	16.6	72.0	128.4
1970	431.8	533.3	7.5	17.5	77.9	136.4
1971	403.4	511.7	7.4	15.8	80.9	136.3
1972	364.1	500.0	8.1	15.1	83.1	129.8
1973	330.6	453.7	8.5	15.0	81.9	123.0
1974	320.1	372.4	8.9	15.4	79.4	124.9
1975	311.8	329.8	9.7	16.6	77.8	126.8
1976	306.4	319.2	9.9	17.0	74.6	121.8
1977	307.6	345.7	10.7	18.8	74.3	125.9
1978	321.8	368.6	10.5	19.5	70.3	124.3
1979	337.6	333.8	11.1	21.2	72.5	128.8
1980	348.6	360.2	11.8	23.6	69.5	120.2
1981	332.9	380.7	12.4	24.6	66.9	117.6
1982			12.9	25.1	67.6	115.8
1983			13.5	26.1	67.1	114.0
1984			13.5	27.6	66.8	116.2

TABLE 12.—ESTIMATED BIRTH RATES FOR MARRIED AND UNMARRIED WOMEN AGES 15–19, BY RACE: 1966 TO 1988—Continued

[Births per 1,000 women]

Year	Marital status, race, and age					
	Married		Unmarried			
	White, 15 to 19	Black, 15 to 19	White		Black	
			15 to 17	18 to 19	15 to 17	18 to 19
1985			14.2	30.9	67.0	121.1
1986			14.6	33.2	67.4	125.0
1987			15.8	34.2	70.4	127.5
1988			17.1	36.4	74.1	136.1

Sources: U.S. National Center for Health Statistics, Vital Statistics of the United States, 1979: Natality, 1–32 and 1–33. And U.S. National Center for Health Statistics Monthly Vital Statistics Report: Advance Report of Final Natality Statistics, 1982, 1983, 1984, 1985,1986, 1987, 1988, 1989, and 1990, table 19.

When studying teenage pregnancy, it is important to note that not all fathers of teenage births are teens themselves. The National Center for Health Statistics reports that, in 1988, approximately 18 percent of male partners of adolescent mothers, age 15–19, were under the age of 20 (table 13). Thirty-two percent of the fathers for this same group were age 20–24. However, there is a large amount of underreporting in this area, particularly for blacks, which prevents the data from showing the complete representation of male fathers to teenage mothers. Thirty-one percent of all white teenage births, age 15 to 19, and as high as 60 percent of all black births of that same group did not report the age of the father.

TABLE 13.—LIVE BIRTHS BY AGE OF FATHER, AGE OF MOTHER, AND RACE OF CHILD, 1988

Age of mother and race of child	Age of father					
	Total	Under 15	15 to 19	20 to 24	25 and older	Not stated
All Races: [1]						
Under 15	10,588	110	2,241	759	156	7,322
15 to 19	478,353	140	87,018	153,525	44,318	193,352
White:						
Under 15	4,073	26	1,031	498	104	2,414
15 to 19	315,471	83	61,959	119,525	34,692	99,212
Black:						
Under 15	6,182	80	1,137	208	38	4,719
15 to 19	146,326	49	22,046	28,588	7,409	88,234

[1] Includes races other than white and black.

Source: National Center for Health Statistics, Vital Statistics of the United States, Vol. 39, No. 4, Supplement, August 15, 1990, Natality, Table 13.

PUBLIC COSTS OF TEENAGE CHILDBEARING [10]

A study by the Center for Population Options (CPO) examines the quantifiable economic impact of teenage pregnancy, that is, what it costs the country each year in taxpayer dollars to support families begun by teenage mothers. Three different sets of public costs are calculated: (1) single year cost, (2) single birth cost, and (3) single cohort cost.

The first, known as single year costs (table 14), shows how much the United States spends as a result of teenage childbearing in a given year. The total public outlay includes expenses for all families in which the first birth occurred when the mother was a teenager, even though the mother may now be considerably older. Although the vast majority of families receiving AFDC assistance have a single, female head-of-household, the CPO estimates do not distinguish between married and unmarried teen mothers.

CPO includes three forms of public assistance in the calculation of the annual costs: Aid to Families with Dependent Children (AFDC), Medicaid, and Food Stamps. The estimates include both direct payments to individuals as well as the administrative and service costs of the programs described. Costs of social service programs for young mothers, special education, foster care, and public housing subsidies are not included in the single-year cost. While some of these expenditures are clearly attributable to teenage childbearing, calculating the dollar amounts on a national level for all families begun by a teen was not considered to be feasible.

TABLE 14.—SINGLE YEAR PUBLIC COST FOR ALL FAMILIES STARTED BY A TEEN BIRTH

[Estimate for 1989 (in billions)]

Funding source	Total outlay for AFDC recipients [1]	Outlay attributable to teenage childbearing [2]
Aid to Families with Dependent Children (AFDC)	$19.68	$10.43
Food Stamps	5.79	3.44
Medicaid	14.17	7.68
Total	39.64	21.55

[1] Includes administrative costs.

[2] Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources.

Source: "Teenage Pregnancy and Too-Early Childbearing: Public Costs, Personal Consequences," Center for Population Options, Washington, DC, 1990.

---

[10] This section borrows heavily from "Teenage Pregnancy and Too-Early Childbearing: Public Costs, Personal Consequences," Center for Population Options, Washington, DC, 1990.

TABLE 15.—PROJECTED PRESENT VALUE PUBLIC COST TO SUPPORT INDIVIDUAL FAMILIES AND ALL FAMILIES BEGUN BY A TEENAGER IN 1989 [1]

Present value estimates over 20-year period 1989–2008

Age	Number of first births [2]	Average single family public cost [3]	Total public cost [4] (in billions)
Under 15	10,234	$21,491	$0.22
15 to 17	151,280	21,446	3.24
18 to 19	212,793	13,579	2.89
Teenagers all ages	374,307	16,975	6.35

[1] Based on AFDC, Medicaid and Food Stamp expenditures.

[2] 1988 natality statistics are the latest available. Monthly Vital Statistics Report, "Advance Report of Final Natality Statistics, 1988," 39.4, August 15, 1990, Table 2.

[3] Cost is expressed in 1989 "present value" dollars, which means that this is the amount that would have to be set aside in 1989 to cover the 20-year cost of the average family begun by a first birth to a teen in 1989, after taking into consideration inflation and the future earning power of a dollar invested in 1989.

[4] Total public cost represents the total cost to support all families begun by a first birth to a teenager in 1989 (estimate based on 1988 statistics).

Source: "Teenage Pregnancy and Too-Early Childbearing: Public Costs, Personal Consequences," Center for Population Options, Washington, DC, 1990.

The second set of figures, single birth costs (table 15), reflects the public cost over a projected twenty-year period for a single family begun in 1989 by a teen birth. This figure represents the average public cost for one family over the first 20 years of a child's life. The figure may appear low because it is an average cost based on the estimated number of all first births to teens in 1989, even though only approximately one-third of families begun with a teen birth are actually recipients of public assistance. The single birth costs are adjusted to reflect two important trends: (1) the probability of receiving public assistance decreases over a teen mother's lifetime, and (2) those who begin childbearing earlier in their teen years are more likely to have more children than those who delay child bearing.

Finally, the third set of costs, single cohort costs (shown as "Total public cost" in table 15), measures what the United States will spend to support all teen families begun in 1989 over the next 20 years. This figure is computed by multiplying the single birth costs for 1989 by the total number of first births to teens in that year. For both single birth costs and single cohort costs, social service and public housing costs are included in the estimates, in addition to AFDC, Medicaid, and food stamp costs used to calculate single year costs.

PRENATAL CARE [11]

Depending on which measure is used, between one quarter and one-third of all pregnant women in the United States do not obtain early, continuous prenatal care. While there is no universally accepted specification for what constitutes "adequate" prenatal care, most of the measures concentrate on the frequency and/or the timing of the care. Prenatal care programs play an important role in alleviating risk factors and improving pregnancy outcomes, particularly if the care is adequate and obtained early.

---

[11] The next three sections borrow heavily from the National Center for Health Statistics. Advance report of final natality statistics, 1988. Monthly Vital Statistics Report, Vol. 39, No. 4 Suppl. DHHS, Hyattsville, MD, 1990, and Prenatal Care; Reaching Mothers, Reaching Infants, Institute of Medicine, National Academy Press, 1989.

Adequate and early care is care that begins early in the first trimester and continues at regular intervals throughout a woman's pregnancy. In its 1988 study of the health of infants and children, the Office of Technology Assessment (OTA) found that early and comprehensive prenatal care can improve the chances of overcoming low birthweight and infant mortality.

Current patterns of use

According to 1988 birth certificate data for the 50 States and the District of Columbia, 73.6 percent of all infants were born to women who obtained early prenatal care, 17.5 percent to women who delayed care (care in the 4th through 6th month), 4.1 percent to women who obtained care late (care after the 6th month), and 1.9 percent to mothers who had no prenatal care at all (table 16). When vital statistics are analyzed to determine rates of adequate care rather than trimester of onset, a slightly different picture emerges. Hughes et al. found that in 1985, only 68.2 percent of all women obtained adequate care, 23.9 percent had an intermediate level of care, and 7.9 percent of all women had inadequate care.

Note that these data do not break out the Hispanic population. As noted below, Hispanic women are at relatively great risk of obtaining insufficient prenatal care. The vast majority (95 percent) of Hispanic births are listed as being of white race on the birth certificate; thus, Hispanic data, when not reported separately, is subsumed mostly in the statistics which apply for whites.

Trends

A panel of specialists reported to the National Institute of Medicine in October 1988 that the consumption of medical care by pregnant women has stagnated or worsened since 1980. Table 17 shows that there was steady improvement from 1969 through 1979 in the percentage of births to mothers receiving early prenatal care (care beginning in the first trimester). Since 1980, the percentage of women receiving early and continued prenatal care has remained stable around 76 percent. Among black women, however, the percentage of babies born to women obtaining care in the first trimester decline from 62.7 to 59.0 percent in 1980 and 1988 respectively. Similarly, the proportion of mothers intiating care in the third trimester or receiving no care at all has remained at 6 percent since 1983, while the rate for black women has increased from 9.7 to 10.5 for those same years. Much of the lack of improvement in early receipt of prenatal care is associated with the increasing proportion of births to unmarried mothers who are much less likely than married mothers to begin care early.

TABLE 16.—MONTH OF PREGNANCY IN WHICH PRENTAL CARE WAS BEGUN (PERCENT), BY AGE OF MOTHER AND RACE OF CHILD, 1988

Age	Month care begun—percent			
	1–3	4–6	7–9	None
All Races				
Under 15	35.1	40.8	14.0	6.2
15 to 19	51.9	32.9	8.7	3.6
20 to 24	68.0	21.8	5.3	2.4
25 to 29	78.9	13.2	2.8	1.3
30 to 34	83.6	11.0	2.2	1.1
35 to 39	81.9	12.1	2.4	1.2
40 and over	75.3	16.3	3.8	1.9
Total	73.6	17.5	4.1	1.9
White				
Under 15	36.9	37.9	14.9	6.4
15 to 19	54.9	31.3	8.1	3.2
20 to 24	71.4	19.8	4.7	1.9
25 to 29	83.3	11.5	2.4	1.0
30 to 34	86.1	9.5	1.8	0.8
35 to 39	84.3	10.7	2.1	1.0
40 and over	77.6	14.8	3.5	1.7
Total	77.8	15.3	3.5	1.4
Black				
Under 15	34.0	43.0	13.5	3.6
15 to 19	45.9	36.2	9.7	3.4
20 to 24	56.6	28.6	7.1	3.4
25 to 29	66.5	21.8	4.8	3.5
30 to 34	69.3	20.0	4.0	3.5
35 to 39	69.2	20.1	4.1	3.6
40 and over	64.3	23.8	5.2	3.5
Total	59.0	27.1	6.6	3.4

Source: National Center for Health Statistics. Advance report of final natality statistics, 1988. Monthly Vital Statistics Report, Vol. 39, No. 4 Suppl. DHHS, Hyattsville, MD, 1990.

TABLE 17.—PERCENTAGE OF BABIES BORN TO WOMEN OBTAINING EARLY CARE, OR LATE OR NO CARE, BY RACE, 1969–88

Year	Percent born to women obtaining early care			Percent born to women obtaining late or no care		
	White	Black	Total	White	Black	Total
1969	72.4	42.7	68.5	6.3	18.2	7.3
1970	72.4	44.3	67.9	6.2	16.6	7.9
1971	73.0	46.6	68.6	5.8	14.6	7.2
1972	73.6	49.0	69.4	5.5	13.2	7.0
1973	74.9	51.4	70.8	5.4	12.4	6.7

TABLE 17.—PERCENTAGE OF BABIES BORN TO WOMEN OBTAINING EARLY CARE, OR LATE OR NO CARE, BY RACE, 1969–88—Continued

Year	Percent born to women obtaining early care			Percent born to women obtaining late or no care		
	White	Black	Total	White	Black	Total
1974	75.9	53.9	72.1	5.0	11.4	6.2
1975	75.9	55.8	72.3	5.0	10.5	6.0
1976	76.8	57.7	73.5	4.8	9.9	5.7
1977	77.3	59.0	74.1	4.7	9.6	5.6
1978	78.2	60.2	74.9	4.5	9.3	5.4
1979	79.1	61.6	75.9	4.3	8.9	5.1
1980	79.3	62.7	76.3	4.3	8.8	5.1
1981	79.4	62.4	76.3	4.3	9.1	5.2
1982	79.3	61.5	76.1	4.5	9.6	5.5
1983	79.4	61.5	76.2	4.6	9.7	5.6
1984	79.6	62.2	76.5	4.7	9.6	5.6
1985	79.4	61.8	76.2	4.7	10.0	5.7
1986	77.6	59.7	74.3	4.9	10.2	5.9
1987	79.9	59.3	74.4	4.9	10.7	6.0
1988	77.8	59.0	74.2	4.9	10.5	6.0

Source: Published and unpublished vital statistics data from the National Center for Health Statistics.

Demographic risk factors

A number of complex and interrelated demographic factors can influence the timing of prenatal care and consequently the incidence of low birthweight infants and infant mortality. Race, income, age, marital status, child birth order, and level of education all are significant risk factors for a woman during her pregnancy.

Race.—There are substantial racial disparities in the use of prenatal care. In 1988, black women were far less likely to begin care early and twice as likely to receive late or no care (table 17). Seventy-nine percent of white mothers compared with 61 percent of black mothers began care in the first trimester. The proportions of white and black mothers who delayed care or received no care also remained at their 1987 levels of 5 percent and 11 percent, respectively. The higher rates of late or no care among black women are probably due to the greater concentration in this population of several risk factors associated with insufficient prenatal care.

When the population is further aggregated by race (not shown), data show that the proportion of Hispanic mothers receiving care in the first trimester was 61 percent in 1988, the same level as for black non-Hispanic mothers, but considerably below the level for white non-Hispanic mothers (82 percent). Additionally, Hispanic women are much more likely to receive care beginning in the third trimester or to have no care at all. In 1988, 12 percent of all Hispanic mothers received late or no prenatal care compared with 4 percent of white non-Hispanic and 11 percent of black non-Hispanic mothers.

Income.—Extensive analysis of National Natality Survey (NNS) data by Singh et al.[12] has yielded the following information on the relationship of income to use of prenatal care: only 66 percent of women with incomes less than 150 percent of the Federal poverty level initiated prenatal care in the first trimester, compared with 85 percent of women with incomes equal to or greater than 250 percent of the poverty level; women with incomes below 150 percent of the poverty level were almost three times as likely to obtain late or no care. Similarly, an analysis of National Survey of Family Growth data found that only 50.4 percent of mothers living below the Federal poverty level, as compared with 73.6 percent of nonpoor mothers, began care in the first trimester of pregnancy.

Age.—Timing of entry into prenatal care also varies with the age of the mother. In general, young mothers are at high risk of obtaining late or no prenatal care, with the greatest risk for adolescent mothers. In 1988, only 53 percent of mothers 15 to 19 years began care in the first trimester compared with 85 percent of mothers 30 to 34 years (table 18). However, teenagers were more likely to receive late or no care than older mothers.

Older mothers, much as teenagers, also tend to delay entry into prenatal care. Mothers age 40 and over are less likely than mothers age 25 to 39 to begin care in the first trimester and more likely to obtain care late or not at all. This tendency increases as women get older, and women over age 45 become as likely as or more likely than mothers age 15 to 19 to obtain late or no care. As for very young teens, however, the number of births to older mothers is small.

Marital status.—Unmarried mothers are more than three times as likely as married mothers to receive late or no care. Unmarried white mothers are almost four times as likely to obtain late or no care; and unmarried black mothers are more than twice as likely to obtain late or no care. This correlation of unmarried status with insufficient prenatal care has become more important in recent years as childbearing among unmarried women has increased.

Education.—Timing of the first prenatal visit is highly associated with the mother's level of educational attainment. In 1988, 92 percent of mothers with college degrees began care in the first trimester compared with only 56 percent of mothers who had less than a high school education. The likelihood of a pregnant woman obtaining late or no care decreases steadily as her educational level increases.

---

[12] Singh S., Torres D., and Forrest J.D. The need for prenatal care in the United States: Evidence from the 1980 National Natality Survey. Fam. Plan. Perspect. 17:122-123, 1985.

TABLE 18.—PERCENT OF BABIES BORN TO MOTHERS OBTAINING LATE OR NO CARE, BY RACE OF CHILD, FOR SELECTED DEMOGRAPHIC RISK FACTORS; 1975, 1980, 1988

	1975			1980			1988		
	White	Black	All	White	Black	All	White	Black	All
Total	4.9	10.4	6.1	4.3	8.8	5.1	5.0	10.9	6.1
Age:									
Under 15	21.1	18.8	19.8	22.6	17.9	20.0	22.1	20.2	21.0
15 to 19	10.6	13.9	11.7	9.4	12.4	10.3	11.7	15.2	12.9
20 to 24	5.8	10.2	6.8	4.6	8.7	5.4	6.8	11.7	7.9
25 to 29	3.0	7.2	3.7	2.5	6.2	3.1	3.4	8.5	4.2
30 to 34	2.5	6.5	3.1	2.5	5.7	3.0	2.6	7.4	3.3
35 to 39	3.5	7.0	4.0	4.3	7.3	4.8	3.1	7.3	3.8
40 and over	6.5	9.3	7.1	7.9	10.3	8.6	5.4	8.7	5.9
Marital Status:									
Married	3.9	7.5	4.4	3.2	5.7	3.5	3.4	5.8	3.7
Unmarried	18.9	13.6	16.2	13.4	11.3	12.5	12.7	13.8	13.3
Total	4.9	104.	6.1	4.2	8.8	5.1	5.0	10.9	6.1
Years of Education:									
0 to 8	13.6	14.4	14.4	13.4	15.2	14.1	15.0	15.7	15.2
9 to 11	8.6	10.2	10.2	8.5	12.6	9.8	10.2	16.0	12.2
12	3.2	4.2	4.2	2.9	7.7	3.8	3.9	10.3	5.4
Over 12	1.6	2.1	2.1	1.4	4.5	1.9	2.7	8.5	3.8
Live Birth Order:									
First	4.8	9.6	5.6	3.8	7.8	4.6	4.3	8.6	5.1
Second	3.9	10.2	4.9	3.5	8.4	4.4	4.2	10.1	5.2
Third	4.9	10.6	6.0	4.5	9.0	5.5	5.6	12.2	6.9
Fourth	7.0	11.7	8.1	6.6	10.6	7.7	8.3	15.3	10.0
Fifth and over	12.6	13.9	13.2	11.3	13.5	12.8	13.4	19.5	15.2

Source: National Center for Health Statistics. Advance report of final natality statistics, 1988. Monthly Vital Statistical Report, Vol. 39, No. 4 Suppl. DHHS, Hyattsville, MD, 1990.

Birth order.—Obtaining late or no care is also associated with birth order. Generally, the more children a woman has had, the more likely she is to delay care or seek none at all. In 1988, 5 percent of all first and second children were born to mothers who obtained late or no care. The numbers rose to 7 percent for third births and to 10 and 15 percent for fourth and fifth children.

Geographic areas of need

Inadequate prenatal care is also concentrated in certain geographic areas. There are wide disparities among states in the percentage of infants born to women obtaining late or no prenatal care (table 19). For example, a woman giving birth in Texas in 1988 was approximately four times as likely as a woman in Iowa or Maine to obtain late or no care, and a nonwhite woman in New Mexico or Pennsylvania was more than four times as likely as a nonwhite woman in Idaho to obtain late or no prenatal care.

Barriers to care

The high incidence of women receiving little or no prenatal care can be partially explained by a number of interrelated factors including a lack of medical insurance; inadequate system capacity such as long waiting periods before receiving care; limited and declining participation of obstetricians and other maternity care providers due to rising malpractice costs and low Medicaid reimbursement rates; and accessibility problems created by long distances to receive care, inadequate transportation, lack of child care, and limited clinic hours.

TABLE 19.—PERCENTAGE OF BABIES BORN TO WOMEN OBTAINING LATE OR NO CARE, ALL RACES, ALL STATES AND THE DISTRICT OF COLUMBIA, 1969, 1975, 1979, 1985, and 1988

State	1969	1975	1979	1985	1988
Alabama			6.3	6.2	6.4
Alaska			5.1	4.4	4.0
Arizona	20.9	13.5	8.1	7.7	10.2
Arkansas			6.3	7.4	7.3
California	7.2	6.0	4.9	5.4	6.1
Colorado		5.2	4.7	5.4	5.3
Connecticut		2.6	2.3	3.0	3.9
Delaware		3.9	4.5	4.3	4.1
District of Columbia	22.8	14.8	8.0	11.4	11.2
Florida		7.8	7.0	9.0	8.2
Georgia		7.5	6.0	5.3	6.9
Hawaii	7.4	5.5	4.9	5.1	5.4
Idaho			5.0	5.4	5.6
Illinios	8.0	6.0	5.2	4.5	5.1
Indiana	6.2	4.1	3.9	5.1	4.9
Iowa	3.5	2.4	2.3	2.1	2.5
Kansas	5.1	4.0	3.4	3.9	3.8
Kentucky	10.2	6.7	7.5	5.1	5.0
Louisiana	9.1	5.9	5.0	4.9	6.9
Maine	5.2	3.0	2.3	3.5	2.8
Maryland	6.7	3.6	3.6	4.1	4.2
Massachusetts	3.8		1.6	2.6	3.1
Michigan (Wayne)	5.4	4.0	3.3	2.9	3.7
Minnesota	7.6	4.2	3.3	3.9	4.4
Mississippi	11.2	6.6	4.5	4.3	4.1
Missouri	8.2	5.5	4.0	4.0	4.4
Montana	6.7	4.4	3.6	4.1	5.1
Nebraska	6.6	4.1	3.4	3.4	3.2
Nevada	7.7	7.4	7.2	6.0	9.4
New Hampshire	4.9	2.8	2.3	2.4	3.0
New Jersey	9.7	5.9	5.1	4.2	5.4
New Mexico			0.0	13.4	16.1
New York (NYC)	11.1	8.3	8.9	8.9	6.9
North Carolina	7.5	5.0	4.2	4.2	5.6

TABLE 19.—PERCENTAGE OF BABIES BORN TO WOMEN OBTAINING LATE OR NO CARE, ALL RACES, ALL STATES AND THE DISTRICT OF COLUMBIA, 1969, 1975, 1979, 1985, and 1988—Continued

State	1969	1975	1979	1985	1988
North Dakota	7.1	5.0	3.3	2.5	2.8
Ohio	5.0	3.5	3.3	3.4	3.8
Oklahoma	8.0	8.2	8.6	7.3	6.3
Oregon		4.9	4.6	5.6	6.4
Pennsylvania			3.9	4.9	5.7
Rhode Island	3.8	1.9	1.7	2.3	3.0
South Carolina	8.1	6.7	6.0	8.0	10.1
South Dakota	10.8	8.1	6.5	5.6	5.8
Tennessee	11.1	6.8	5.3	5.5	5.2
Texas	13.1	9.4	8.1	11.0	11.5
Utah	3.8	2.0	2.6	3.1	2.8
Vermont	7.0	4.8	3.4	3.5	3.7
Virginia			3.4	4.0	4.2
Washington	4.7	3.8	3.6	4.7	5.0
West Virginia	11.5	8.8	6.3	6.1	5.9
Wisconsin	4.6	2.6	2.7	3.0	3.3
Wyoming	7.1	5.1	4.7	4.3	4.6
Total	8.2	6.0	5.1	5.7	6.1

Source: National Center for Health Statistics. Advance report of final natality statistics, 1988, Monthly Vital Statistics Report, Vol. 39, No. 4 Suppl. DHHS, Hyattsville, MD, 1990.

Relationships among demographic risk factors.—To assess the comparative importance of selected demographic factors in predicting use of prenatal care, researchers constructed estimates of relative risk for late or no prenatal care for various groups. In this analysis, 17 populations (including the total U.S. population) are compared with the group in the United States that has the best rates of prenatal care utilization—married, white, and nonpoor women. The question is posed: Compared with the reference group, how many times more likely is group X to obtain late or no prenatal care? As shown in table 20, unmarried women had the greatest relative risk of late or no care. Teenagers, women with less than a high school education, Hispanic women, and women with incomes less than 150 percent of the Federal poverty level also faced substantially greater risks.

TABLE 20.—NUMBER OF MOTHERS OBTAINING LATE OR NO PRENATAL CARE AND RELATIVE RISK, REFERENCE GROUP, SELECTED SUBGROUPS, AND TOTAL POPULATION, UNITED STATES, 1980

Subgroup	Number (thousands)	Relative risk
Reference group—married, white, nonpoor [1]		[2] 1.0
Age:		
Under 20	55	4.3
20 to 24	61	2.0
25 and over	53	1.3
Race/ethnic origin:		
Black (non-Hispanic)	39	3.1
White (non-Hispanic)	104	1.6
Hispanic	26	4.0
Marital status:		
Married	90	1.4
Unmarried	79	5.1
Residence:		
Metropolitan	108	2.0
Nonmetropolitan	61	2.2
Education (years):		
Less than 12	77	4.0
12	65	1.7
13 or more	27	1.0
Income (percent of poverty level):		
Less than 150	100	3.7
150 to 249	22	1.1
250 or more	47	1.3
Total	169	2.0

[1] An income of 150 percent of the poverty level or more is considered nonpoor.

[2] Risk of 1.0 for the reference group represents a level of inadequate care of 2 percent (with inadequate care defined as care in the third trimester or no care). For each other subgroup, risk is computed by dividing the proportion in that subgroup receiving inadequate care by the proportion in the reference group receiving comparable care.

Source: Singh S, Torres D., and Forrest J.D. The need for prenatal care in the United States: Evidence from the 1980 National Natality Survey. Fam. Plan. Perspect. 17:122–123, 1985, tables 5 and 6.

INFANT MORTALITY

The infant mortality rate is defined as the number of babies born alive who die before reaching the age of 1. In 1988, there were 38,910 deaths of infants under the age of 1 with an infant mortality rate of 10.0 deaths per 1,000 live births. (This compares to a rate of 10.1 for the previous year.) The mortality rate for black infants was 17.6, more than two times as high as the white infant mortality rate of 8.5 (table 21). The infant death rate for the Hispanic population in a reporting area of 23 States and the District of Columbia was 8.1 deaths per 1,000 live births. For all infants and for infants of both major race groups considered separately, the decline in infant mortality rates between 1987 and 1988 was not statistically significant.

TABLE 21.—INFANT MORTALITY RATES FOR THE UNITED STATES BY RACE AND SEX, 1988

	Overall	White	All other	Black
Total	10.0	8.5	15.0	17.6
Male	11.0	9.5	16.2	19.0
Female	8.9	7.4	13.8	16.1

Source: National Center for Health Statistics. Advance report of final natality statistics, 1988. Monthly Vital Statistics Report, Vol. 39, No. 4. Suppl. DHHS, Hyattsville, MD, 1990.

Until recently, the absolute difference in infant mortality rates between black and white infants was narrowing—in 1960 the difference in rates was 21.4 infants per 1,000 live births compared with 9.3 in 1987 and 9.1 in 1988. However, because the infant mortality rates for the white and black populations have been decreasing by about the same average annual percent between 1960 and 1988, the black infant mortality rate in 1988 continued to be about twice the white rate. The downward trend in infant mortality has slowed for both the white populations—since the late 1970s for white infants and since 1981 for black infants (table 22).

On a State-by-State basis, the infant mortality rates ranged from 6.8 in Vermont to 12.5 and 12.6 in North Carolina and Georgia, respectively (table 23 and chart 8). The mortality rate for infants in the District of Columbia was 23.2, far surpassing the highest State rates and exceeding the rates in all major U.S. cities.

State infant mortality rates vary dramatically by race. As noted in the previous subsection, data for Hispanics, unless specifically broken out, are mostly subsumed in the data for whites. In every region of the country, the black infant mortality rate is substantially higher than the white rate. Eight States and the District of Columbia have black infant mortality rates (average annual 1985–87) above 19.0: District of Columbia (23.5), Michigan (22.2), Illinois (21.4), North Carolina and West Virginia (21.3), Delaware (21.0), Pennsylvania (20.8), Indiana (20.1), and Connecticut (19.6).

While caution should be used when looking at infant mortality rates for cities, the District of Columbia, Detroit, and Baltimore have consistently high infant mortality rates across all races (table 24).

TABLE 22.—INFANT MORTALITY RATES, BY RACE AND SEX: SELECTED YEARS

Year	All races	White	All other	
			Total	Black
Infant Mortality Rate [1]				
1940	47.0	43.2	73.8	72.9
1950	29.2	26.8	44.5	43.9
1960	26.0	22.9	43.2	44.3
1970	20.0	17.8	30.9	32.6
1975	16.1	14.2	24.2	26.2
1980	12.6	11.0	19.1	21.4
1981	11.9	10.5	17.8	20.0
1982	11.5	10.1	17.3	19.6
1983	11.2	9.7	16.8	19.2
1984	10.8	9.4	16.1	18.4
1985	10.6	9.3	15.8	18.2
1986	10.4	8.9	15.7	18.0
1987	10.1	8.6	15.4	17.9
1988	10.0	8.5	15.0	17.6
1989	9.7	NA	NA	NA
1990	9.1	NA	NA	NA
Neonatal Mortality Rate [2]				
1940	28.8	27.2	39.7	39.9
1950	20.5	19.4	27.5	27.8
1960	18.7	17.2	26.9	27.8
1970	15.1	13.8	21.4	22.8
1975	11.6	10.4	16.8	18.3
1980	8.5	7.5	12.5	14.1
1981	8.0	7.1	11.8	13.4
1982	7.7	6.8	11.3	13.1
1983	7.3	6.4	10.8	12.4
1984	7.0	6.2	10.2	11.8
1985	7.0	6.1	10.3	12.1
1986	6.7	5.8	10.1	11.7
1987	6.5	5.5	10.0	11.7
1988	6.3	5.4	9.7	11.5
Postneonatal Mortality Rate [3]				
1940	18.3	16.0	34.1	33.0
1950	8.7	7.4	16.9	16.1
1960	7.3	5.7	16.4	16.5
1970	4.9	4.0	9.5	9.9
1975	4.5	3.8	7.5	7.9
1980	4.1	3.5	6.6	7.3
1981	3.9	3.4	6.0	6.6
1982	3.8	3.3	5.9	6.6
1983	3.9	3.3	6.0	6.8
1984	3.8	3.3	5.8	6.5
1985	3.7	3.2	5.5	6.1
1986	3.6	3.1	5.6	6.3
1987	3.6	3.1	5.4	6.1
1988	3.6	3.1	5.4	6.2

---

[1] Deaths before the age of one.

[2] Deaths under 28 days.

[3] Deaths from 28 days to 11 months.

Source: National Center for Health Statistics. Advance report of final natality statistics, 1988. Monthly Vital Statistics Report, Vol. 39, No. 4 Suppl. DHHS, Hyattsville, MD, 1990.

TABLE 23.—INFANT MORTALITY RATES, ACCORDING TO RACE, GEOGRAPHIC DIVISION, AND STATE: UNITED STATES, AVERAGE ANNUAL 1975–77, 1980–82, 1985–87, AND 1988

[Infant deaths per 1,000 live births]

Geographic division and State	All Races			White 1985–87	Black 1985–87	All Races 1988
	1975–77	1980–82	1985–87			
United States	15.1	12.0	10.4	9.0	18.0	10.0
New England	12.8	10.4	8.6	8.0	18.1	8.1
Maine	11.2	9.7	8.7	8.8	(1)	7.9
New Hampshire	11.6	10.2	8.7	8.7	(1)	8.3
Vermont	11.9	9.2	9.0	8.9	(1)	6.8
Massachusetts	12.5	10.1	8.3	7.5	17.6	7.9
Rhode Island	13.7	10.9	8.7	8.4	[1] 13.0	8.2
Connecticut	14.4	11.5	9.2	7.9	19.6	8.9
Middle Atlantic	15.3	12.2	10.5	8.8	18.0	10.3
New York	15.5	12.4	10.7	9.2	16.7	10.8
New Jersey	14.7	11.7	9.9	8.0	18.4	9.9
Pennsylvania	15.3	12.2	10.5	8.8	20.8	9.9
East North Central	15.2	12.5	10.8	9.0	20.1	10.5
Ohio	14.9	12.2	10.1	9.0	16.5	9.7
Indiana	14.5	11.7	10.8	9.7	20.1	11.0
Illinois	17.0	14.1	11.8	9.3	21.4	11.3
Michigan	15.2	12.7	11.2	8.9	22.2	11.1
Wisconsin	12.5	10.0	9.0	8.3	17.1	8.4
West North Central	14.0	11.0	9.5	8.8	17.0	8.9
Minnesota	12.8	9.9	8.9	8.6	16.5	7.8
Iowa	13.4	10.7	9.0	8.9	[1] 14.9	8.7
Missouri	15.3	12.3	10.4	9.1	17.7	10.1
North Dakota	14.1	11.3	8.6	8.3	(1)	10.5
South Dakota	16.5	10.9	11.0	9.1	(1)	10.1
Nebraska	13.6	10.5	9.4	8.8	[1] 18.0	9.0
Kansas	13.8	10.7	9.2	8.7	16.3	8.0
South Atlantic	16.9	13.8	11.8	9.2	18.5	11.6
Delaware	13.6	13.8	12.7	10.2	21.0	11.8
Maryland	16.2	12.8	11.7	9.1	18.1	11.3
District of Columbia	27.2	23.8	20.4	11.6	23.5	23.2
Virginia	16.5	13.0	10.9	8.8	18.0	10.4
West Virginia	16.6	12.1	10.3	9.8	[1] 21.3	9.0
North Carolina	17.3	13.8	11.7	9.4	17.8	12.5
South Carolina	18.8	16.0	13.4	9.8	19.2	12.3
Georgia	16.5	13.6	12.6	9.7	18.3	12.6
Florida	16.1	13.6	10.9	8.7	18.3	10.6

TABLE 23.—INFANT MORTALITY RATES, ACCORDING TO RACE, GEOGRAPHIC DIVISION, AND STATE: UNITED STATES, AVERAGE ANNUAL 1975–77, 1980–82, 1985–87, AND 1988—Continued

[Infant deaths per 1,000 live births]

Geographic division and State	All Races			White 1985–87	Black 1985–87	All Races 1988
	1975–77	1980–82	1985–87			
East South Central	17.3	13.6	11.8	9.4	18.3	11.4
Kentucky	14.9	12.3	10.3	9.8	15.3	10.7
Tennessee	15.9	12.7	11.4	8.9	19.5	10.8
Alabama	18.7	14.0	12.7	9.6	18.7	12.1
Mississippi	20.6	16.0	13.3	9.4	17.8	12.3
West South Central	16.2	12.0	10.1	8.8	16.2	9.4
Arkansas	16.3	11.6	10.8	9.5	15.0	10.7
Louisiana	18.0	13.7	11.9	8.4	17.3	11.0
Oklahoma	15.5	12.3	10.3	10.2	16.6	9.0
Texas	15.7	11.5	9.5	8.6	15.5	9.0
Mountain	13.7	10.5	9.5	9.3	15.1	9.2
Montana	15.2	11.1	10.0	9.3	(1)	8.7
Idaho	12.5	10.0	10.7	10.7	(1)	8.8
Wyoming	15.8	10.1	10.8	10.8	(1)	8.9
Colorado	13.1	9.7	9.3	9.0	16.5	9.6
New Mexico	15.4	10.9	9.4	9.2	[1] 17.3	10.0
Arizona	14.5	11.1	9.5	9.1	14.3	9.7
Utah	11.6	10.4	9.0	9.1	(1)	8.0
Nevada	15.1	10.7	9.1	8.8	[1] 15.3	8.4
Pacific	12.8	10.5	9.3	9.0	16.0	8.6
Washington	14.1	11.0	10.1	10.0	13.8	9.0
Oregon	13.2	11.2	9.9	9.9	[1] 18.0	8.6
California	12.6	10.4	9.2	8.8	16.2	8.6
Alaska	15.3	12.0	10.7	9.4	[1] 13.3	11.6
Hawaii	11.7	9.6	9.0	8.1	[1] 15.5	7.2

---

[1] Data for States with fewer than 5,000 live births for the 3-year period are considered unreliable. Data for States with fewer than 1,000 live births are considered highly unreliable and are not shown.

Source: National Center for Health Statistics: Data computed by the Division of Analysis from data compiled by the Division of Vital Statistics.

CHART 8. U.S. INFANT MORTALITY RATES (DEATHS PER 1,000 LIVE BIRTHS)

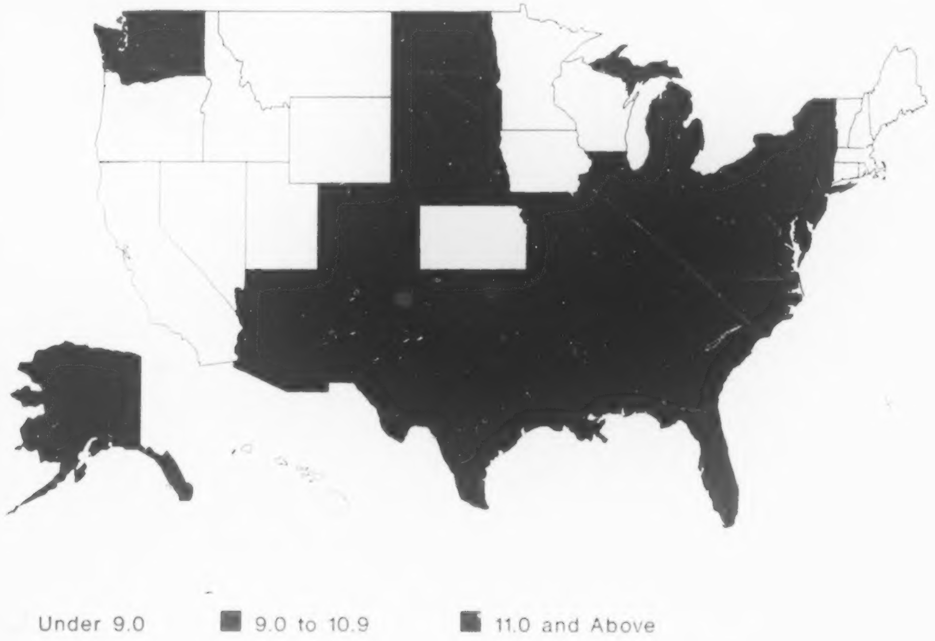

Under 9.0
■ 9.0 to 10.9
■ 11.0 and Above

TABLE 24.—LIVE BIRTHS, INFANT DEATHS, AND INFANT MORTALITY RATES BY RACE FOR 22 CITIES OF 500,000 POPULATION OR MORE IN 1980: 1988

[Rates are deaths under 1 year per 1,000 live births in specified group]

City	All races			White			All other					
							Total			Black		
	Rate	Infant deaths	Live births	Rate	Infant deaths	Live births	Rate	Infant deaths	Live births	Rate	Infant deaths	Live births
Baltimore	18.0	244	13,556	12.9	51	3,959	20.1	193	9,597	20.4	191	9,378
Boston	13.9	135	9,723	8.4	41	4,857	19.3	94	4,866	22.1	92	4,155
Chicago	15.2	858	56,559	9.9	262	26,464	19.8	596	30,095	21.0	584	27,746
Cleveland	17.0	179	10,521	12.2	57	4,655	20.8	122	5,866	20.9	120	5,749
Columbus, OH	14.2	158	11,139	12.5	95	7,572	17.7	63	3,567	18.0	58	3,214
Dallas	9.3	191	20,487	8.2	105	12,838	11.2	86	7,649	12.3	86	7,002
Detroit	21.0	414	19,729	13.6	56	4,111	22.9	358	15,618	23.1	355	15,399
Houston	11.3	414	36,484	9.1	218	23,833	15.5	196	12,651	17.0	185	10,908
Indianapolis	12.6	172	13,670	9.7	94	9,681	19.6	78	3,989	20.1	77	3,822
Jacksonville, FL	11.3	129	11,465	9.6	71	7,364	14.1	58	4,101	14.7	58	3,952
Los Angeles	10.1	772	76,516	8.3	470	56,880	15.4	302	19,636	20.2	265	13,141
Memphis	17.6	217	12,330	9.0	36	3,995	21.7	181	8,335	21.6	178	8,234
Milwaukee	12.1	147	12,191	7.8	49	6,280	16.6	98	5,911	17.5	95	5,432
New Orleans	12.7	122	9,618	[1] 4.8	10	2,088	14.9	112	7,530	15.5	111	7,159
New York City	13.2	1,684	127,448	11.0	780	70,963	16.0	904	56,485	18.3	864	47,132
Philadelphia	17.5	506	28,979	12.0	151	12,622	21.7	355	16,357	22.5	346	15,371
Phoenix	10.9	210	19,237	10.1	169	16,734	16.4	41	2,503	23.5	35	1,492
San Antonio	9.5	167	17,520	8.9	142	15,891	15.3	25	1,629	18.0	25	1,392
San Diego	8.1	153	18,993	7.6	101	13,341	9.2	52	5,652	13.9	39	2,800
San Francisco	8.4	84	10,034	9.6	44	4,574	7.3	40	5,460	13.3	23	1,723
San Jose	7.8	126	16,234	7.8	90	11,534	7.7	36	4,700	[1] 15.2	15	990
Washington, DC	23.2	245	10,540	19.9	33	1,661	23.9	212	8,879	26.0	212	8,165

[1] Based on less than 20 infant deaths.

Note: Caution should be used in ranking infant mortality rates for cities because differences in the rates may not be statistically significant.

Source: National Center for Health Statistics.

International comparisons

The United States has one of the worst rates of infant mortality among all Western industrialized countries. In 1987, the United States ranked 19th in infant mortality behind Spain, Singapore, and Hong Kong (table 25). Throughout this century, the United States and the majority of the industrialized world made great progress in reducing the number of deaths among newborns and infants. While the United States was never a leader, in 1918, the United States ranked 6th among 20 selected countries. However, during the 1980s, the United States began to lose ground. The mortality rate for black infants matches the entire infant mortality rates for Poland, Hungary, Portugal, and Costa Rica, which have the highest infant death rates among 32 nations according to UNICEF.

TABLE 25.—INFANT MORTALITY RATES, SELECTED COUNTRIES, 1979, 1984, AND 1987

[Infant death per 1,000 live births]

Country	Infant mortality rate		
	1979	1984 [1]	1987 [3]
Japan	7.9	6.0	5.0
Sweden	7.5	6.4	5.7
Finland	7.7	6.5	5.8
Switzerland	8.5	7.5	6.8
Denmark	8.8	7.7	8.3
France	10.0	8.2	7.6
Netherlands	8.7	8.3	7.6
Norway	8.8	8.3	8.4
Canada	10.9	8.5	7.3
Australia	11.4	9.2	8.8
Federal Republic of Germany	13.5	9.6	8.3
United Kingdom	12.9	9.6	9.1
Spain	12.8	9.7	8.5
German Democratic Republic	12.9	10.0	8.5
Belgium	11.2	10.7	9.7
United States	13.1	10.8	10.1
Austria	14.7	11.4	9.9
Italy	15.3	11.6	9.8
New Zealand	12.6	11.6	10.0
Israel	15.9	12.8	11.4
Greece [2]	18.7	14.1	12.6

---

[1] Data for Switzerland, Canada, and Spain are for 1983; 1984 data for France, Belgium, and Cuba are provisional.

[2] Registration coverage estimated to be less than 90 percent complete.

[3] Data for Finland, Australia, Italy, and Israel are for 1986; data for Spain are for 1985.

Source: United Nations: Demographic Yearbook, 1981 and 1985. Pub. Nos. ST/ESA/STAT/SER.R/11 and ST/ESA/STAT/SER.R/15. New York. United Nations, 1983 and 1987; National Center for Health Statistics: Advance report of final mortality statistics, 1984. Monthly Vital Statistics Report, vol. 35, No. 6, Supp. 2, DHHS pub. No. (PHS) 86–1120. Public Health Service. Hyattsville, Md., Sept. 26, 1986; Vital Statistics of the United States, vol. II, Mortality, part A, 1979. Public Health Service. Washington. U.S. Government Printing Office; for 1984, Public Health Service. United Nations Statistical Office, Population and Vital Statistics, April 1989.

LOW BIRTH WEIGHT

The high infant death rate in the United States is strongly related to the number of infants whose weight at birth is lower than normal for their gestational age or who were born prematurely. Low birth weight is the single greatest cause of infant death. Low birth weight is defined as those infants born weighing less than 2,500 grams (5.8 pounds). Very low birth weight babies weigh less than 1,500 grams (3.5 pounds). The lower the birth weight, the greater the risk of such lifelong disabilities as cerebral palsy, autism, epilepsy, and mental retardation or even infant death. The Office for Technological Assessment reports that in 1980, low birth weight infants represented less than 7 percent of all newborns in the United States but accounted for 60 percent of all babies who died during infancy. Major advances in improving the infant mortality rate have been achieved through saving the lives of premature infants, not in reducing the prevalence of low birth weight.

In 1988, although the overall rate of low birth weight remained unchanged from the 1987 level (6.9 percent), the already substantial racial disparity increased further. Among black births, the incidence of low birth weight increased from 12.7 percent in 1987 to 13.0 percent, the highest level since 1976; the rate for white infants fell from 5.7 percent in 1987 to 5.6 percent in 1988 (table 26).

The incidence of low birth weight is associated with the mother's age. Babies born to teenagers and to mothers 40 years and over are at the greatest risk of being low birth weight (8.2 to 13.6 percent). Mothers ages 25 to 29 and 30 to 34 are least likely to have a low birth weight baby (6.1 to 6.3 percent).

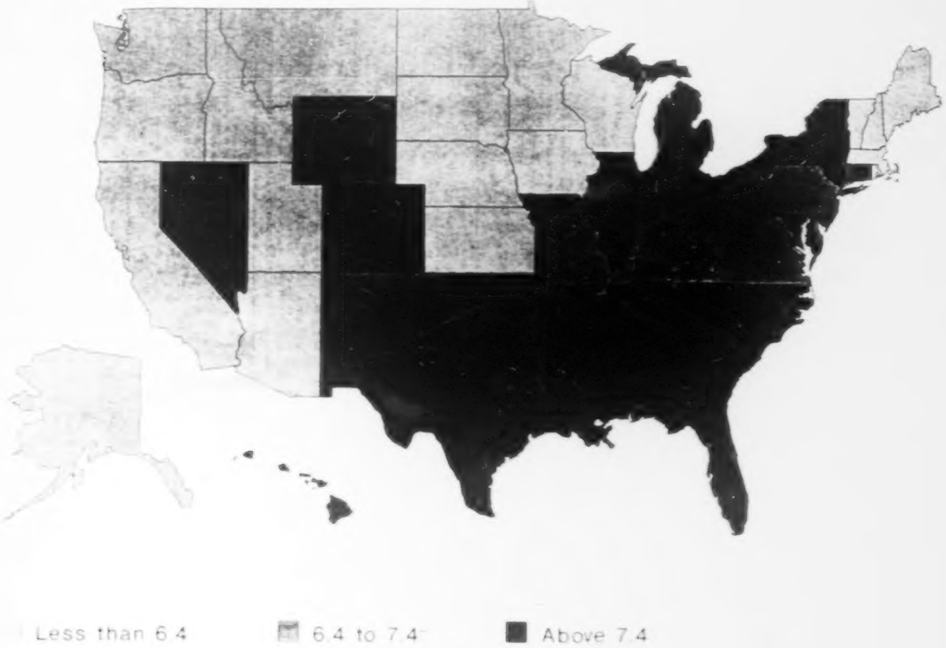
In the United States, between 1987 and 1988, levels of low birth weight among white babies increased in 16 States and the District of Columbia and declined in 24 States; no changes were observed in 10 States. Among the 37 States and the District of Columbia with at least 1,000 black births in 1988, the proportions of low birth weight black infants increased in 24 States and the District of Columbia, fell in 12 States, and did not change in 1 State (chart 9).

TABLE 26.—NUMBER AND PERCENT OF LOW BIRTH WEIGHT AND VERY LOW BIRTH WEIGHT BIRTHS, BY AGE OF MOTHER AND RACE OF CHILD, 1988

Age of mother, race of child	Total births	Low birthweight		Very low birthweight	
		Number	Percent	Number	Percent
All races:					
All ages	3,909,510	270,681	6.9	48,580	1.2
Under 15	10,588	1,433	13.6	362	3.4
15 to 19	478,353	44,231	9.3	8,411	1.8
20 to 24	1,067,472	76,442	7.2	13,316	1.2
25 to 29	1,239,256	75,953	6.1	13,229	1.1
30 to 34	803,547	50,243	6.3	9,101	1.1
35 to 39	269,518	19,025	7.1	3,574	1.3
40 to 44	39,349	3,214	8.2	563	1.4
45 to 49	1,427	140	9.8	24	1.7
White:					
All ages	3,046,162	171,775	5.6	28,216	0.9
Under 15	4,073	445	11.0	112	2.7
15 to 19	315,471	23,695	7.5	4,176	1.3
20 to 24	804,622	46,776	5.8	7,317	0.9
25 to 29	1,010,748	50,814	5.0	8,080	0.8
30 to 34	661,414	34,559	5.2	5,801	0.9
35 to 39	217,754	13,175	6.1	2,323	1.1
40 to 44	31,068	2,217	7.1	390	1.3
45 to 49	1,012	94	9.3	17	1.7
All other:					
All ages	863,348	98,906	11.5	20,364	2.4
Under 15	6,515	988	15.2	250	3.8
15 to 19	162,882	20,536	12.6	4,235	2.6
20 to 24	262,850	29,666	11.3	5,999	2.3
25 to 29	228,508	25,139	11.0	5,149	2.3
30 to 34	142,133	15,684	11.0	3,300	2.3
35 to 39	51,764	5,850	11.3	1,251	2.4
40 to 44	8,281	997	12.1	173	2.1
45 to 49	415	46	11.1	7	1.7
Black:					
All ages	671,976	87,009	13.0	18,648	2.8
Under 15	6,182	955	15.5	245	4.0
15 to 19	146,326	19,254	13.2	4,024	2.8
20 to 24	220,301	26,959	12.3	5,629	2.6
25 to 29	167,684	21,754	13.0	4,696	2.8
30 to 34	93,765	12,766	13.6	2,879	3.1
35 to 39	32,534	4,564	14.0	1,038	3.2
40 to 44	4,981	726	14.6	132	2.7
45 to 49	203	31	15.3	5	2.5

Source: National Center for Health Statistics. Advance report of final natality statistics, 1988. Monthly Vital Statistics Report, Vol. 39, No. 4 Suppl. DHHS, Hyattsville, MD, 1990.

CHART 9. PERCENT OF LOW BIRTH WEIGHT BIRTHS IN THE UNITED STATES, 1988



DRUG-ADDICTED MOTHERS AND THEIR INFANTS[13]

Infants are increasingly at risk due to parental drug addiction. To understand the scope of this newly emerging social problem, the House Select Committee on Children, Youth, and Families sampled major municipal hospitals throughout the United States, conducting a telephone survey of 14 public and 4 private facilities located in 15 cities: Boston, Chicago, Dallas, Denver, Detroit, Houston, Los Angeles, Miami, New York, Oakland, Philadelphia, Phoenix, San Antonio, Seattle and the District of Columbia. Survey interviews with personnel in one or two hospitals in each of these cities focused on the following: (1) trends in births of drug-exposed infants, (2) whether and how pregnant women and/or their infants are screened for illegal substances, (3) length of stay in the hospital, and (4) costs associated with substance-exposed infants. While the study is definitely limited in scope, the data do provide a snapshot of the prevalence and impact of drugs on pregnant women and their infants.

1. *Birth trends.*—Of the 18 hospitals surveyed, 15 (14 public and 1 private) reported an increase in the incidence of substance abuse during pregnancy, as well as the number of drug-exposed infants born since 1985. Eight of the eighteen hospitals surveyed had trend

---

[13] This section borrows heavily from "Born Hooked: Confronting the Impact of Perinatal Substance Abuse," a report of the Select Committee on Children, Youth, and Families, April 1989.

data available, although none of the hospitals reported routinely screening all newborns or pregnant women for drug exposure. For example, a New York City hospital reported that, based on toxic screening, the number of drug-exposed newborns increased from 12 to 13 percent of 2,900 to 3,000 births in 1985 to 15 percent of the same total number of births in 1988. Of the 18 hospitals surveyed, 9 suggested that the numbers of drug-exposed infants and substance-abusing pregnant women were undercounted. Underestimation can be attributed to: (1) maternal denial of drug use, (2) lack of clinician sensitivity to indicators of drug use, (3) and the inaccuracy of toxic screening. For example, a pediatrician in a Detroit hospital stated that urine toxicologies only detect 37 percent of positive drug-exposures because of the test's high rate of false negatives. Hospital personnel cited physical and behavioral characteristics of drug-exposed newborns: prematurity, low birthweight, hypertonicity, and low Apgar scores.

2. *Health care.*—Seven of the eighteen hospitals surveyed related that substance-abusing pregnant women were as much as 4 times less likely to receive prenatal care than other women. Twelve of the eighteen hospitals reported that they have no place to send pregnant women for drug treatment. For example, a Los Angeles hospital noted a 10- to 16-week waiting period for drug treatment, even for pregnant women.

3. *Placement of drug-exposed infants.*—Eight of the eighteen hospitals pointed out that drug-exposed newborns medically cleared for discharge regularly remain in the hospital for a variety of reasons. Such reasons may include lack of appropriate foster care or delayed protective services evaluation. For example, a Miami hospital daily houses 20 to 30 "boarder babies," who may remain in the hospital for as long as a month, due, in part, to the effect of a State law placing all drug-exposed newborns under State custody, thereby overwhelming the foster care system.

4. *Hospital costs.*—Eight of the eighteen hospitals referred to the high cost of care for low birthweight and sick babies, an increasing number of whom are drug-exposed. For example, a Los Angeles hospital estimated the average cost of a drug-exposed newborn in the intensive care nursery as approximately $750 per day for a mildly drug-exposed newborn and $1,768 per day for a severely affected infant. Six of the eighteen hospitals mentioned a lack of resources to confront the problem of drug-exposed newborns.

CHILD HEALTH [14]

Immunizations

Table 27 shows vaccination rates of children 1 to 4 years of age for five childhood illnesses: measles, rubella, DTP, polio, and mumps. A comparison of the years 1970 and 1985 reveals that, with the exception of DTP and polio which declined in prevalence, the proportion of children aged 1 to 4 immunized against each of the major childhood diseases increased slightly for measles, with larger increments for rubella and mumps. For mumps, data are available for 1976 on. "All other" races were less frequently immunized than whites. As of 1985, approximately 30 to 40 percent of white children and 50 to 60 percent of "all other" children were not immunized against the common childhood diseases.

---

[14] Except where otherwise noted, this section borrows heavily from National Center for Health Statistics: "Health, United States, 1989." DHHS Pub. No. (PHS) 89-1232. Public Health Service. Washington. U.S. Government Printing Office, March 1990.

TABLE 27.—VACCINATIONS OF CHILDREN 1–4 YEARS OF AGE FOR SELECTED DISEASES, ACCORDING TO RACE: UNITED STATES, 1970, 1976, AND 1983–85

[Data are based on household interviews of a sample of the civilian noninstitutionalized population]

Vaccination and year	Total	Race	
		White	All other
All Respondents	Percent of Population		
Measles:			
1970	57.2	60.4	41.9
1976	65.9	68.3	54.8
1983	64.9	66.8	57.2
1984	62.8	65.4	52.0
1985	60.8	63.6	48.8
Rubella:			
1970	37.2	38.3	31.8
1976	61.7	63.8	51.5
1983	64.0	66.3	54.7
1984	60.9	63.9	48.3
1985	58.9	61.6	47.7
DTP: [1, 2]			
1970	76.1	79.7	58.8
1976	71.4	75.3	53.2
1983	65.7	70.1	47.7
1984	65.7	69.1	51.3
1985	64.9	68.7	48.7
Polio: [2]			
1970	65.9	69.2	50.1
1976	61.6	66.2	39.9
1983	57.0	61.9	36.7
1984	54.8	58.4	39.9
1985	55.3	58.9	40.1
Mumps:			
1970			
1976	48.3	50.3	38.7
1983	59.5	61.8	50.0
1984	58.7	61.3	47.7
1985	58.9	61.8	47.0

[1] Diphtheria-tetanus-pertussis.

[2] 3 doses or more.

Note: Beginning in 1976, the category "don't know" was added to response categories. Prior to 1976, the lack of this option resulted in some forced positive answers, particularly for vaccinations requiring multiple dose schedules, that is, polio and DTP.

Source: National Center for Health Statistics: "Health, United States, 1989." DHHS Pub. No. (PHS) 89–1232. Public Health Service. Washington. U.S. Government Printing Office, March 1990.

AIDS

Over the next few years, the number of Americans afflicted with acquired immunodeficiency syndrome (AIDS) is expected to increase dramatically (see table 28). As of September 30, 1989, there were a total of 25,467 cases reported, with 22,442 of these occurring among males 13 years of age and over, 2,553 among females 13 years of age and over, and the remaining 472 cases among children under 13 years. The figures are substantially higher than those reported for each of these groups, respectively, in 1983: 2,066, 1,891, 141, and 34. Table 28 shows the average annual growth rate for the periods 1983 to 1988 and 1987 to 1988.

Of the total AIDS cases reported in 1989 among males 13 years of age and over, 61.4 percent are white, 24.8 are black, and 12.8 are Hispanic; among females of the same ages, 28.8 percent are white, 54.4 are black and 15.6 percent are Hispanic; and, finally, among children under 13 years, 23.2 percent are white, 55.1 percent are black and 20.8 percent are Hispanic (see table 29). The majority of AIDS cases, then, among males occur among whites, while among females and children, they occur among blacks. For males 13 years of age and over, the largest percentage of AIDS cases are 30–39 years of age (46.9 percent); for females 13 years of age and over, they are also 30–39 years of age (47.2 percent); and for children under 13 years, they are 1–12 years of age (60.1 percent).

TABLE 28.—ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) CASES, ACCORDING TO AGE AT DIAGNOSIS, SEX, AND RACE/ETHNICITY: UNITED STATES, 1983–89

[Data are based on reporting by State health departments]

Age at diagnosis, sex, and race/ethnicity	Number, by year of report							Average annual growth rate	
	1983	1984	1985	1986	1987	1988	1989 [1]	1983–88	1987–88
Total [2]	2,066	4,445	8,205	13,167	21,140	30,947	25,467	71.8	7.9
Male									
All males, 13 years and over [2]	1,891	4,118	7,551	12,011	19,137	27,313	22,442	70.6	7.4
White, not Hispanic	1,138	2,611	4,806	7,545	12,352	16,256	13,305	70.2	5.6
Black, not Hispanic	479	947	1,718	2,765	4,332	7,151	6,046	71.7	10.5
Hispanic	268	538	972	1,592	2,255	3,645	2,815	68.5	10.1
Female									
All females, 13 years and over [2]	141	277	525	970	1,684	3,064	2,553	85.1	12.7
White, not Hispanic	34	79	143	272	544	864	723	91.0	9.7
Black, not Hispanic	67	141	284	523	896	1,663	1,438	90.1	13.2
Hispanic	38	57	94	162	230	502	357	67.6	16.9
Children									
All children, under 13 years [2]	34	50	129	186	319	570	472	75.7	12.3
White, not Hispanic	7	10	25	43	86	152	84	85.1	12.1
Black, not Hispanic	22	28	86	107	161	302	264	68.9	13.4
Hispanic	5	12	18	35	69	111	117	85.9	10.0
Under 1 year	19	33	56	77	138	193	184	59.0	6.9
1 to 12 years	15	17	73	109	181	377	288	90.6	15.8

---

[1] Data are as of September 30, 1989, and reflect reporting delays. [2] Includes all other races not shown separately.

Note: The AIDS case definition as changed in September 1987 to allow for the presumptive diagnosis of AIDS-associated diseases and conditions and to expand the spectrum of human Immunodeficiency virus-associated diseases reportable as AIDS. Excludes residents of U.S. territories.

Source: Centers for Disease Control, Center for Infectious Diseases, AIDS Program.

TABLE 29.—ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) CASES AND DEATHS, ACCORDING TO AGE AT DIAGNOSIS, SEX, AND RACE/ETHNICITY: UNITED STATES, ALL YEARS

[Data are based on reporting by State health departments]

Age at diagnosis, sex, and race/ethnicity	Number of cases	Percent of distribution	Deaths [1]	Percent distribution
Total [2]	106,270	....	63,159	....
Male				
All males, 13 years and over [2]	95,231	100.0	56,722	100.0
White, not Hispanic	58,462	61.4	34,424	60.7
Black, not Hispanic	23,648	24.8	14,610	25.8
Hispanic	12,192	12.8	7,196	12.7
13 to 19 years	317	0.3	177	0.3
20 to 29 years	19,105	20.1	10,795	19.0
30 to 39 years	44,680	46.9	25,862	45.6
40 to 49 years	21,201	22.3	12,975	22.9
50 to 59 years	7,264	7.6	4,921	8.7
60 years and over	2,664	2.8	1,992	3.5
Female				
All females, 13 years and over [2]	9,266	100.0	5,457	100.0
White, not Hispanic	2,668	28.8	1,590	29.1
Black, not Hispanic	5,045	54.4	2,998	54.9
Hispanic	1,449	15.6	816	15.0
13 to 19 years	76	0.8	46	0.8
20 to 29 years	2,553	27.6	1,462	26.8
30 to 39 years	4,376	47.2	2,487	45.6
40 to 49 years	1,259	13.6	727	13.3
50 to 59 years	463	5.0	300	5.5
60 years and over	539	5.8	435	8.0
Children				
All children under 13 years [2]	1,773	100.0	980	100.0
White, not Hispanic	411	23.2	251	25.6
Black, not Hispanic	977	55.1	516	52.7
Hispanic	369	20.8	201	20.5
Under 1 year	707	39.9	489	49.9
1 to 12 years	1,066	60.1	491	50.1

---

[1] Data are as of September 30, 1989, and reflect reporting delays.

[2] Includes all other races not shown separately.

Note: The AIDS case definition was changed in September 1987 to allow for the presumptive diagnosis of AIDS-associated diseases and conditions and to expand the spectrum of human immunodeficiency virus-associated diseases reportable as AIDS. Excludes residents of U.S. territories.

Source: Centers for Disease Control, Center for Infectious Diseases, AIDS Program.

Technology-dependence

Technology-dependent children are a subset of the much larger population of chronically ill children. The term "technology-dependent" refers to those children who use a medical technology (embodied in a medical device) that compensates for the loss of normal use of a vital body function, and who require substantial daily skilled nursing care to avert death or further disability. Estimates of the numbers of technology-dependent children in the United States who require frequent and complex nursing tasks range from 2,300 to 15,000. These children require ventilator assistance, parenteral nutrition, intravenous drugs, or other device-based respiratory or nutritional supports.[15] If the term is broadened to include children with chronic conditions who require less frequent treatment and intermittent nursing care, the technology-dependent child population could number 30,000 or more. Table 30 shows estimates of the size of the technology-dependent child population. Care outside hospitals and nursing facilities is safe and feasible for many technology-dependent children.

TABLE 30.—SUMMARY OF OTA ESTIMATES OF THE SIZE OF THE TECHNOLOGY-DEPENDENT CHILD POPULATION, 1987

Defined population	Estimated number of children
Group I: Requiring ventilator assistance	680 to 2,000
Group II:	
Requiring parenteral nutrition	350 to 700
Requiring prolonged intravenous drugs	270 to 8,275
Group III: Requiring other device-based respiratory or nutritional support	1,000 to 6,000
Rounded subtotal (I+II+III)	2,300 to 17,000
Group IV:	
Requiring apnea monitoring	6,800 to 45,000
Requiring renal dialysis	1,000 to 6,000
Requiring other device-associated nursing	Unknown, perhaps 30,000 or more

Source: Office of Technology Assessment, 1987.

Use of selected substances

Substance abuse continues to be a major health threat. Table 31 describes the use of selected substances (cigarettes, alcohol, marijuana, and cocaine) by youths (12 to 17 years of age) and young adults (18 to 25 years of age). Trends in self-reported use (based on household interviews) are broken down by age and sex. Overall, there is a clear downward trend. Most recent (1988) data for reported use shows that consumption of alcohol, marijuana, and cocaine is much higher among males 18 to 25 years of age, as compared with males 12 to 17 years of age and females 12 to 17 and 18 to 25 years of age.

---

[15] Technology-Dependent Children: Hospital v. Home Care, U.S. Office of Technology Assessment, May 1987.

The Drug Abuse Warning Network (DAWN) furnishes statistics on the number of people admitted to emergency rooms following the use of cocaine. These data are based on a nonrandom sample of 562 participating emergency rooms in 21 metropolitan areas and 78 medical examiner facilities, primarily located in 27 metropolitan areas. The following figures are noteworthy: Between 1985 and 1988 the yearly number of cocaine-related emergency room visits in DAWN hospitals rose sharply from 11,136 to 46,825. Cocaine-related emergency room visits grew from 304 to 1,027 for youths 12 to 17 years of age and from 3,552 to 14,434 for young adults 18 to 25 years of age.

TABLE 31.—USE OF SELECTED SUBSTANCES IN THE PAST MONTH BY YOUTHS 12–17 YEARS OF AGE AND YOUNG ADULTS 18–25 YEARS OF AGE, ACCORDING TO AGE AND SEX: UNITED STATES, SELECTED YEARS 1974–88

[Data are based on household interviews of a sample of the population 12 years of age and over in the coterminous United States]

Substance, age, and sex	1974	1976	1979	1982	1985	1988
Cigarettes	Percent of population					
Both sexes:						
12 to 17 years	25	23	(1)	15	15	12
12 to 13 years	13	11	(1)	[3] 3	6	3
14 to 15 years	25	20	(1)	10	14	11
16 to 17 years	38	39	(1)	30	25	20
18 to 25 years	49	49	(1)	40	37	35
Male:						
12 to 17 years	27	21	(1)	16	16	12
18 to 25 years	50	48	(1)	37	38	36
Female:						
12 to 17 years	24	26	(1)	13	15	11
18 to 25 years	47	51	(1)	42	35	35
Alcohol [2]						
Both sexes:						
12 to 17 years	34	32	37	27	31	25
12 to 13 years	19	19	20	10	11	6
14 to 15 years	32	31	36	23	35	23
16 to 17 years	51	47	55	45	46	42
18 to 25 years	69	69	76	68	71	65
Male:						
12 to 17 years	39	36	39	27	34	27
18 to 25 years		79	84	75	78	75
Female:						
12 to 17 years	29	29	36	27	28	23
18 to 25 years		58	68	61	64	57

TABLE 31.—USE OF SELECTED SUBSTANCES IN THE PAST MONTH BY YOUTHS 12–17 YEARS OF AGE AND YOUNG ADULTS 18–25 YEARS OF AGE, ACCORDING TO AGE AND SEX: UNITED STATES, SELECTED YEARS 1974–88—Continued

[Data are based on household interviews of a sample of the population 12 years of age and over in the coterminous United States]

Substance, age, and sex	1974	1976	1979	1982	1985	1988
Marijuana						
Both sexes:						
12 to 17 years	12	12	17	12	12	6
12 to 13 years	[3] 2	[3] 3	4	[3] 2	[3] 4	1
14 to 15 years	12	13	17	8	11	5
16 to 17 years	20	21	28	23	21	12
18 to 25 years	25	25	35	27	22	15
Male:						
12 to 17 years	12	14	19	13	13	6
18 to 25 years		31	45	36	27	20
Female:						
12 to 17 years	11	11	14	10	11	7
18 to 25 years		19	26	19	17	11
Cocaine						
Both sexes:						
12 to 17 years	[3] 1.0	[3] 1.0	1.4	1.6	1.5	1.1
18 to 25 years	3.1	2.0	9.3	6.8	7.6	4.5
Male:						
12 to 17 years				1.8	2.0	0.9
18 to 25 years				9.1	9.0	6.0
Female:						
12 to 17 years				[3] 1.5	[3] 1.0	1.4
18 to 25 years				4.7	6.3	3.0

[1] Data not comparable because definitions differ.

[2] In 1979, 1982, 1985, and 1988, private answer sheets were used for alcohol questions; in earlier years, respondents answered questions aloud.

[3] Relative standard error greater than 30 percent.

Source: National Institute on Drug Abuse.

Developmental, learning, and emotional problems [16]

Parents responding to the 1988 National Health Interview Survey of Child Health reported that 4.0 percent of U.S. children aged 17 years and under have had a delay in their growth or development (table 32). This means that an estimated 2.5 million children have developmental delays. In addition, 6.5 percent of children ages 3 to 17, or 7 million, have had an emotional or behavioral problem that lasted 3 months or more or required psychological treatment. Seen in the aggregate, the result is that a total of 19.5

---

[16] This section borrows heavily from Zill, Nicholas and Charlotte A. Schoeborn, National Center for Health Statistics, "Developmental Learning and Emotional Problems: Health of Our Nation's Children, United States, 1988," Vital and Health Statistics, Number 190, November 16, 1990, Tables 1–4.

percent of children aged 3 to 17, or nearly 10.2 million, have had one or more developmental, learning, or emotional disorders. Combined with the 488,000 children aged 2 and under who had developmental delays, the total number affected by one or more of the above conditions amounts to almost 10.7 million.

Parents who reported that their child had a delay in development, a learning disability, or an emotional or behavioral problem were asked whether the child "has ever received treatment or counseling" for the condition (table 33). For example, 2 percent of all children ages 17 and under had received treatment or counseling for a delay in growth or development. This amounted to 49 percent of all those reported to have such a delay. One percent of all children were reported to have received treatment for developmental delays within the previous 12 months.

TABLE 32.—PERCENT OF ALL CHILDREN 3–17 YEARS OF AGE WHO EVER HAD A DELAY IN GROWTH OR DEVELOPMENT, A LEARNING DISABILITY, OR AN EMOTIONAL PROBLEM THAT LASTED 3 MONTHS OR MORE OR REQUIRED PSYCHOLOGICAL HELP, BY AGE AND SELECTED CHARACTERISTICS: UNITED STATES, 1988

Characteristics of children	All ages 3–17 years	3–5 years	6–11 years	12–17 years
Ever had a delay in growth or development	[1] 4.0	4.4	4.1	3.6
Ever had a learing disability	6.5	1.6	6.8	8.8
Ever had an emotional or behavioral problem that lasted 3 months or more or required psychological help	13.4	5.3	12.7	18.5
Children who ever had a delay in growth or development, a learning disability, or an emotional problem that lasted 3 months or more or required psychological help				
All children	19.5	9.5	19.1	25.2
Sex				
Male	22.9	10.5	22.8	29.2
Female	16.0	8.5	15.4	20.8
Race				
White	20.7	10.0	20.3	26.7
Black	14.9	5.0	14.8	19.5
Hispanic origin				
Hispanic	17.2	8.5	19.6	19.2
Non-Hispanic	19.9	9.7	19.1	25.8
Family income				
Less than $10,000	22.8	11.5	23.8	28.6
$10,000 to $24,999	21.0	10.1	21.3	27.3
$25,000 to $39,999	19.5	11.3	17.6	26.0
$40,000 or more	18.6	6.8	18.0	24.1
Assessed health status				
Excellent, very good, or good	19.1	8.9	18.7	24.8
Fair or poor	35.3	25.7	35.7	39.3

TABLE 32.—PERCENT OF ALL CHILDREN 3–17 YEARS OF AGE WHO EVER HAD A DELAY IN GROWTH OR DEVELOPMENT, A LEARNING DISABILITY, OR AN EMOTIONAL PROBLEM THAT LASTED 3 MONTHS OR MORE OR REQUIRED PSYCHOLOGICAL HELP, BY AGE AND SELECTED CHARACTERISTICS: UNITED STATES, 1988—Continued

Characteristics of children	All ages 3–17 years	3–5 years	6–11 years	12–17 years
Family structure				
Biological mother and father	14.6	8.1	14.4	19.2
Biological mother and stepfather	29.6	14.4	27.0	34.5
Biological mother only [2]	24.8	11.7	24.5	31.4
All other	28.2	13.5	29.7	31.4

[1] Includes all children 17 years and under.

[2] Includes families in which the mother lived with the child's grandmother or other adult relative.

Source: Zill, Nicholas and Charlotte A. Schoenborn, National Center for Health Statistics, "Developmental Learning and Emotional Problems; Health of Our Nation's Children, United States States, 1988," Vital and Health Statistics, Number 190, November 16, 1990, Tables 1–4.

TABLE 33.—PROPORTION OF CHILDREN EVER TREATED AND PROPORTION RECEIVING SPECIAL EDUCATION FOR DELAYS IN GROWTH OR DEVELOPMENT, LEARNING DISABILITIES, AND EMOTIONAL OR BEHAVIORAL PROBLEMS: UNITED STATES, 1988

Treatment and special education status	Delays in growth or development—Ages 0–17		Learning disabilities—Ages 3–17		Emotional or behavioral problems—Ages 3–17	
	Percent of all children	Percent distribution of all children with condition	Percent of all children	Percent distribution of all children with condition	Percent of all children	Percent distribution of all children with condition [1]
Ever received treatment or counseling for condition						
Total	4.0	100.0	6.5	100.0	13.4	100.0
Yes	2.0	49.4	5.1	77.7	10.0	74.5
Within last 12 months	1.1	26.1	3.3	50.3	5.1	38.0
More than 12 months ago	0.9	23.3	1.8	27.4	4.7	35.3
No	2.0	50.6	1.5	22.3	3.4	25.5

TABLE 33.—PROPORTION OF CHILDREN EVER TREATED AND PROPORTION RECEIVING SPECIAL EDUCATION FOR DELAYS IN GROWTH OR DEVELOPMENT, LEARNING DISABILITIES, AND EMOTIONAL OR BEHAVIORAL PROBLEMS: UNITED STATES, 1988—Continued

Treatment and special education status	Delays in growth or development—Ages 6-17		Learning disabilities—Ages 6-17		Emotional or behavioral problems—Ages 6-17	
	Percent of all children	Percent distribution of all children with condition	Percent of all children	Percent distribution of all children with condition	Percent of all children	Percent distribution of all children with condition[1]
Attended special classes or special school in past 12 months status because of condition						
Total	3.9	100.0	7.8	100.0	6.9	100.0
Yes	0.9	22.7	5.5	69.9	1.7	24.9
No	3.0	77.3	2.3	30.1	5.2	75.1

[1] Includes unknown when treated; excludes unknown whether treated.

[2] Question about receipt of special educational services asked only of those who reported an emotional or behavioral problem that lasted 3 months or longer.

Note: Numbers may not add to totals because of rounding. Data are based on household interviews of the civilian noninstitutionalized population.

Source: Zill, Nicholas and Charlotte A. Schoenborn, National Center for Health Statistics, "Developmental Learning and Emotional Problems: Health of Our Nation's Children, United States, 1988," Vital and Health Statistics, Number 190, November 16, 1990, Tables 1-4.

Leading causes of child death by age group[17]

Children are most at risk of dying in the first year of life. In 1988, there were nearly 39,000 infant deaths in the United States, for a death rate of about 1,000 deaths per 100,000 live births, or about 1 percent (table 34). After the first year, death rates fell steeply, to 51 deaths per 100,000 children ages 1 to 4, and 26 deaths per 100,000 children ages 5 to 14. Death rates rose again to 102 per 100,000 in adolescence and young adulthood (ages 15 to 24).

The major causes of death also change with age. In the first year of life, the leading causes of death are birth defects, the sudden infant death syndrome, and syndromes and problems that arise out of pregnancy, childbirth, and the period shortly after birth. After the first year, accidental injury is the leading cause of death to young people. Motor vehicle accidents play a major role, especially during adolescence and young adulthood. Homicide was the second leading cause of death in the 15 to 24 age range, and among the top ten causes for 1 to 4 and 5 to 14 year olds. Suicide was the third leading cause of death among 15 to 24 year olds, and one of the top 10 causes for 5 to 14 year olds.

---

[17] "U.S. Children and Their Families: Current Conditions and Recent Trends, 1989," a report of the Select Committee on Children, Youth, and Families, September, 1989.

TABLE 34.—NUMBER OF DEATHS AND DEATH RATE IN 1988 FOR LEADING CAUSES OF CHILD DEATH, BY AGE GROUP

Rank order	Cause of death	Number of deaths	Death rate
	Under 1 Year		
	All causes	38,910	995.3
1	Congenital anomalies (birth defects)	8,141	208.2
2	Sudden infant death syndrome	5,476	140.1
3	Respiratory distress syndrome	3,268	83.6
4	Disorders relating to short gestation and low birth weight	3,181	81.4
5	Newborn affected by maternal complications of pregnancy	1,411	36.1
6	Intrauterine hypoxia and birth asphyxia	936	23.9
7	Infections specific to the perinatal period	907	23.2
8	Accidents and adverse effects	878	22.5
9	Newborn affected by complications of placenta, cord, and membranes.	777	19.9
10	Pneumonia and influenza	641	16.4
	Homicide	315	8.1
	child battering and maltreatment	108	2.8
	other homicide	207	5.3
	All other causes	13,294	340.0
	1 to 4 Years		
	All causes	7,429	50.9
1	Accidents and adverse effects	2,858	19.6
	Motor vehicle accidents	1,005	6.9
	All other accidents	1,853	12.7
2	Congenital anomalies (birth defects)	913	6.3
3	Cancer, leukemia	542	3.7
4	Homicide	381	2.6
5	Heart disease	352	2.4
6	Pneumonia and influenza	186	1.3
7	Meningitis	129	0.9
8	Conditions originating in the perinatal period	129	0.9
9	Septicemia	114	0.8
10	Meningococcal infection	89	0.6
	All other causes	1,736	11.9
	5 to 14 Years		
	All causes	8,925	25.8
1	Accidents and adverse effects	4,215	12.2
	Motor vehicle accidents	2,423	7.0
	All other accidents	1,792	5.2
2	Cancer, leukemia	1,096	3.2
3	Congenital anomalies (birth defects)	499	1.4
4	Homicide	459	1.3
5	Heart disease	324	0.9
6	Suicide	243	0.7
7	Pneumonia and influenza	127	0.4
8	Asthma and other chronic obstructive pulmonary diseases	103	0.3
9	Carcinoma and other tumors	103	0.3
10	Cerebrovascular diseases (stroke)	72	0.2

TABLE 34.—NUMBER OF DEATHS AND DEATH RATE IN 1988 FOR LEADING CAUSES OF CHILD DEATH, BY AGE GROUP—Continued

Rank order	Cause of death	Number of deaths	Death rate
	All other causes	1,684	4.9
	15 to 24 Years		
	All causes	38,167	102.1
1	Accidents and adverse effects	18,507	49.5
	Motor vehicle accidents	14,406	38.5
	All other accidents	4,101	11.0
2	Homicide	5,771	15.4
3	Suicide	4,929	13.2
4	Cancer, leukemia	1,894	5.1
5	Heart disease	1,090	2.9
6	Congenital anomalies (birth defects)	535	1.4
7	Pneumonia and influenza	474	1.3
8	Cerebrovascular diseases (stroke)	266	0.7
9	Asthma and other chronic obstructive pulmonary diseases	266	0.7
10	Diabetes mellitus	178	0.5
	All other causes	4,257	11.4

Note: Death rates for those under 1 year are deaths per 100,000 live births. Death rates for other age groups are deaths per 100,000 population in age group.

Source: National Center for Health Statistics, "Advance Report of Final Mortality Statistics, 1988," Monthly Vital Statistics Report, Vol. 39, No. 7, Supplement, November 28, 1990, Tables 7 and 14.

Tables 35 through 38 show death rates for children and young adults from under 1 year to 24 years of age. In 1987, the death rate for all causes for all races 15 to 24 years of age was 99.4 (table 22). For the same group in 1988, the, death rate for motor vehicle accidents was 38.5 (table 23), for homicide and legal intervention 15.4 (table 24), and for suicide 12.9 (table 38). Thus, 65 percent of the overall death rate can be explained by the latter three categories of causes.

With respect to death rates for suicide for children and young adults (table 38), the rates are much higher for 15 to 24 year olds (12.9) than 5 to 14 year olds (0.7), for white males (22.7) than black males (12.9), for white females (4.6) than black females (2.5), and for males (35.6) than females (7.1).

TABLE 35.—DEATH RATES FOR ALL CAUSES, ACCORDING TO SEX, RACE, AND AGE: UNITED STATES, 1950 TO 1988

[Deaths per 100,000 resident population]

Sex, race and age	1950	1960	1970	1980	1988
All races					
Under 1 year	3,299.2	2,696.4	2,142.4	1,288.3	1,008.3
1 to 4 years	139.4	109.1	84.5	63.9	50.9
5 to 14 years	60.1	46.6	41.3	30.6	24.2
15 to 24 years	128.1	106.3	127.7	115.4	102.1
White males					
Under 1 year	3,400.5	2,694.1	2,113.2	1,230.3	930.5
1 to 4 years	135.5	104.9	83.6	66.1	51.0
5 to 14 years	67.2	52.7	48.0	35.0	25.4
15 to 24 years	152.4	143.7	170.8	167.0	139.7
Black males					
Under 1 year		5,306.8	4,298.9	2,586.7	2,167.7
1 to 4 years		208.5	150.5	110.5	90.5
5 to 14 years	95.1	75.1	67.1	47.4	41.9
15 to 24 years	289.7	212.0	320.6	209.1	223.3
White females					
Under 1 year	2,566.8	2,007.7	1,614.6	962.5	728.2
1 to 4 years	112.2	85.2	66.1	49.3	40.2
5 to 14 years	45.1	34.7	29.9	22.9	18.5
15 to 24 years	71.5	54.9	61.6	55.5	49.2
Black females					
Under 1 year		4,162.2	3,368.8	2,123.7	1,821.5
1 to 4 years		173.3	129.4	84.4	70.7
5 to 14 years	72.2	53.8	43.8	30.5	29.5
15 to 24 years	213.1	107.5	111.9	70.5	69.0

Source: National Center for Health Statistics: "Health, United States, 1989." DHHS Pub. No. (PHS) 89-1232. Public Health Service. Washington. U.S. Government Printing Office, March 1990.

Note: Death rates under 1 year (based on population estimates) differ from infant mortality rates (based on live births).

TABLE 36.—DEATH RATES FOR MOTOR VEHICLE ACCIDENTS, ACCORDING TO SEX, RACE, AND AGE: UNITED STATES, 1950 TO 1988

[Deaths per 100,000 resident population]

Sex, race and age	1950	1960	1970	1980	1988
All Races					
Under 1 year	8.4	8.1	9.8	7.0	5.6
1 to 4 years	11.5	10.0	11.5	9.2	6.9
5 to 14 years	8.8	7.9	10.2	7.9	7.0
15 to 24 years	34.4	38.0	47.2	44.8	38.5
15 to 24 years					
White male	58.3	62.7	75.2	73.8	[1] 59.2
Black male	41.6	46.4	58.1	34.9	[1] 36.2
White female	12.6	15.6	22.7	23.0	[1] 21.7
Black female	11.5	9.9	13.4	8.0	[1] 9.5

[1] Data from 1987.

Source: National Center for Health Statistics: "Health, United States, 1989." DHHS Pub. No. (PHS) 89-1232. Public Health Service. Washington. U.S. Government Printing Office, March 1990.

TABLE 37.—DEATH RATES FOR HOMICIDE AND LEGAL INTERVENTION, ACCORDING TO SEX, RACE AND AGE; UNITED STATES 1950 TO 1988

[Deaths per 100,000 resident population]

Sex, race, and age	1950	1960	1970	1980	1988
All races					
5 to 14 years	0.5	0.5	0.9	1.2	1.3
15 to 24 years	6.3	5.9	11.7	15.6	15.4
15 to 24 years					
White male	3.7	4.4	7.9	15.5	[1] 11.2
Black male	58.9	46.4	102.5	84.3	[1] 85.6
White female	1.3	1.5	2.7	4.7	[1] 3.9
Black female	16.5	11.9	17.7	18.4	[1] 17.7

[1] Data from 1987.

Source: National Center for Health Statistics: "Health, United States, 1989." DHHS Pub. No. (PHS) 89-1232. Public Health Service. Washington. U.S. Government Printing Office, March 1990.

TABLE 38.—DEATH RATES FOR SUICIDE ACCORDING TO SEX, RACE, AND AGE: IN UNITED STATES, 1950 TO 1987

[Deaths per 100,000 resident population]

Sex, race and age	1950	1960	1970	1980	1988
All races					
5 to 14 years	0.2	0.3	0.3	0.4	0.7
15 to 24 years	4.5	5.2	8.8	12.3	13.2
15 to 24 years					
White male	6.6	8.6	13.9	21.4	[1] 22.7
Black male	4.9	4.1	10.5	12.3	[1] 12.9
White female	2.7	2.3	4.2	4.6	[1] 4.6
Black female	1.8	1.3	3.8	2.3	[1] 2.5

[1] Data from 1987.

Source: National Center for Health Statistics: "Health, United States, 1989." DHHS Pub. No. (PHS) 89-1232. Public Health Service. Washington. U.S. Government Printing Office, March, 1990.

Juveniles in custody [18]

The number of juveniles in custody in public correctional facilities on a given day in 1987 was 53,503, or 208 per 100,000 juveniles in the United States. This was a 10-percent increase over the number of juveniles in custody on a comparable day in 1983, and an 18-percent increase in the proportion of juveniles incarcerated 5 years earlier. During the course of the year, over 590,000 juveniles were admitted to public facilities. Data on juveniles in custody in private facilities are not yet available beyond 1985, but in that year 41 percent of all juveniles in custody were in private facilities.

Juveniles in public facilities were predominantly male, and disproportionately black, and four-fifths were 14 to 17 years old. Most of the juveniles in custody, 94 percent, were held for commiting offenses that would be criminal if commited by adults. One quarter of the juveniles were being held for having commited violent crimes, and nearly 45 percent for property crimes such as burglary, larceny, and auto theft. The number in custody primarily for drug- and alcohol-related offenses increased by 56 percent between 1985 and 1987.

---

[18] U.S. House Select Committee on Children, Youth and Families. "U.S. Children and their Families: Current Conditions and Recent Trends, 1989," Report 101-356, U.S. Government Printing Office, 1989.

TABLE 39.—NUMBER OF JUVENILES IN PUBLIC AND PRIVATE JUVENILE FACILITIES, AND RATE PER 100,000 JUVENILES IN THE POPULATION, 1975–1987

	1975	1979	1983	1985	1987
Number of juveniles	74,270	71,922	80,091	83,403	....
Public	46,980	43,234	48,701	49,322	53,503
Private	27,290	28,688	31,390	34,080	N/A
Rate (per 100,000)	241	251	290	313	....
Public	152	151	176	185	208
Private	89	100	114	128	N/A

Source: "Children in Custody," Office of Juvenile Justice and Delinquency Prevention, October 1986 and 1988; and unpublished data from the Office of Juvenile Justice and Delinquency Prevention, 1989.

EDUCATIONAL ACHIEVEMENT

Proficiency areas [19]

Growing concern about the quality of education in the United States has prompted careful scrutiny of student learning outcomes. Tables 40 through 42 represent the percentage of students at or above various levels of proficiency in four areas of achievement: math, reading, science, and writing. Overall, student performance has been mediocre. According to tables 41 and 42, students have achieved better at lower than higher levels of proficiency and minority students have achieved less well than white students. Over time, some progress has been made, as the year by year comparisons show. Gains are particularly noteworthy for blacks and Hispanics.

Table 43 shows the mean reading proficiency scores for 9-, 13-, and 17-year olds, broken down by race, community type and level of parental education.

---

[19] Data for this section have been drawn from National Center for Education Statistics, "Digest of Education Statistics," 1990 and from Berlin, Gordon and Andrew Sum. "Toward a More Perfect Union: Basic Skills, Poor Families, and Our Economic Future," Occasional Paper 3, Ford Foundation, New York, New York, 1988.

TABLE 40.—PERCENTAGE OF STUDENTS AT OR ABOVE AN INTERMEDIATE LEVEL OF PROFICIENCY IN FOUR ACHIEVEMENT AREAS: UNITED STATES, 1971–88

Achievement areas [1]	1971	1975	1979 [2]	1982	1986 [3]
9-year-olds					
Writing			63.7	[3] 58.2	....
Science			26.2	24.8	27.6
Math			19.4	18.7	20.8
Reading	15.3	14.6	17.2	[3] 17.0	[4] 17.0
13-year-olds					
Writing			27.8	[3] 34.1	....
Science			49.2	51.5	53.4
Math			64.9	71.6	73.1
Reading	57.9	58.6	60.9	[3] 59.1	[4] 58.0
17-year-olds					
Writing			60.6	[3] 63.8	....
Science			81.8	76.8	80.8
Math			92.1	92.9	96.0
Reading	78.5	80.4	81.0	[3] 83.1	[4] 86.2

---

[1] For each of the subject matter areas (writing, science, math, and reading), a task was selected at an intermediate level of performance, as follows: for writing, persuasion defined as attempting to bring about some action or change; for science, applying basic scientific information; for math, engaging in basic operations and beginning problem solving; and for reading, able to search for specific information, interrelate ideas, and make generalizations about literature, science, and social studies materials. The writing level is a minimal level of performance that varies by grade level.

[2] Data for the 1979 column were obtained from a variety of years, as follows: 63.7 (1979), 26.2 (1977), 19.4 (1978), 17.2 (1980), 27.8 (1979), 49.2 (1977), 64.9 (1978), 60.9 (1980), 60.6 (1979), 81.8 (1977), 92.1 (1978), and 81.0 (1980). This was done because these were the only scores available for these years.

[3] 1984 data.

[4] 1988 data.

Source: National Center for Education Statistics, "Digest of Education Statistics," 1989.

TABLE 41.—PERCENTAGE OF WHITE, BLACK, AND HISPANIC STUDENTS AT OR ABOVE VARIOUS LEVELS OF PROFICIENCY IN FOUR ACHIEVEMENT AREAS; UNITED STATES, SELECTED YEARS

	9-year-olds				13-year-olds				17-year-olds			
	Total	White	Black	Hispanic	Total	White	Black	Hispanic	Total	White	Black	Hispanic
Reading levels (1987–88):												
Rudimentary [1]	93.0	94.9	85.6	86.1	99.8	99.9	99.7	99.1	(a)	(a)	(a)	(a)
Basic [2]	62.5	68.3	39.2	46.9	95.1	96.6	90.7	86.3	98.9	99.5	97.1	96.4
Intermediate [3]	17.0	19.7	5.9	8.2	58.0	63.3	39.2	34.9	86.2	89.3	76.0	72.9
Adept [4]	1.2	1.4	0.1	0.0	10.6	12.3	4.0	3.1	41.8	46.3	25.8	24.3
Advanced [5]	(b)	(b)	(b)	(b)	(b)	(b)	(b)	(b)	4.9	5.8	1.9	1.3
Math levels (1985–86):												
Simple arithmetic facts	97.8	98.9	93.0	96.4	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Beginning skills and understanding	73.9	79.2	53.3	58.7	98.5	99.2	95.5	96.1	99.9	99.9	100.0	98.9
Basic operations and beginning problem solving	20.8	24.5	5.4	8.0	73.1	78.7	49.4	55.2	96.0	98.3	86.0	90.8
Moderately complex procedure and reasoning	0.6	0.7	(b)	(b)	15.9	18.6	4.0	5.4	51.1	58.0	21.7	26.8
Multi-step problem and algebra	(b)	(b)	(b)	(b)	0.4	0.5	0.1	0.3	6.4	7.6	0.3	1.2
Science levels (1985–86):												
Know everyday science facts	96.3	98.5	87.5	89.6	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Understand simple scientific principles	71.4	78.4	45.1	49.1	91.8	96.4	74.3	76.1	96.7	98.6	89.8	92.9
Apply basic scientific information	27.6	32.6	8.8	10.7	53.4	61.9	20.2	27.6	80.0	87.6	52.9	61.6

Analyze scientific procedures and data	3.4	4.3	.4	.2	9.4	11.8	.9	1.6	41.4	48.8	12.3	15.5
Integrate specialized scientific info	(b)	(b)	(b)	(b)	.2	.3	(b)	(b)	7.5	9.0	1.0	0.5
Writing levels (1984):												
Informative writing	55.7	59.7	36.0	51.9	81.4	84.9	64.4	78.8	89.0	91.3	79.5	86.1
Persuasive writing	58.2	62.6	40.1	50.9	34.1	37.0	26.2	19.9	63.8	67.2	55.7	52.9
Imaginative writing	54.6	57.3	44.8	46.2	66.7	65.3	75.3	65.7	75.1	76.4	68.4	76.2

(a) Virtually all students were able to perform at this level.
(b) Virtually no students were able to perform at this level.

[1] Able to follow brief written directions and select phrases to describe pictures.

[2] Able to understand combined ideas and make reference based on short uncomplicated passages about specific or sequentially related information.

[3] Able to search for specific information, interrelate ideas, and make generalizations about literature, science,and social studies materials.

[4] Able to find, understand, summarize, and explain relatively complicated literary and informational material.

[5] Able to understand the links between ideas and even when those links are not explicitly stated and to make appropriate generalizations even when the texts lack clear introductions or explanations.

NA Data not available.

Source: National Center for Education Statistics, "Digest of Education Statistics," 1990.

TABLE 42.—PERCENTAGE OF 17-YEAR-OLDS AT OR ABOVE VARIOUS LEVELS OF PROFICIENCY IN FOUR ACHIEVEMENT AREAS: UNITED STATES, 1978–1988

	White			Black			Hispanic		
	1978	1986	Difference	1978	1986	Difference	1978	1986	Difference
Math levels									
Simple arithmetic facts [1]	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Beginning skills and understanding	100.0	99.9	—.1	98.7	100.0	1.3	99.3	98.9	—.4
Basic operations and beginning problem solving	95.8	98.3	2.5	70.0	86.0	16.0	77.4	90.8	13.4
Moderately complex procedures and reasoning	57.3	58.0	.7	18.0	21.7	3.7	22.1	26.8	4.7
Multi-step problem and algebra	8.6	7.6	—1.0	.4	.3	—.1	1.1	1.2	.1

	1975	1988	Difference	1975	1988	Difference	1975	1988	Difference
Reading levels									
Rudimentary [1]	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Basic [2]	98.6	99.5	.9	81.1	97.1	16.0	88.3	96.4	8.1
Intermediate [3]	86.1	89.3	3.2	42.4	76.0	33.6	51.9	72.9	21.0
Adept [4]	44.0	46.3	2.3	7.9	25.8	17.9	12.9	24.3	11.4
Advanced [5]	7.0	5.7	—1.3	.3	1.9	1.6	1.1	1.3	.2

Science levels									
Knows everyday science facts [1]	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Understand simple scientific principles	99.2	98.6	−.6	84.5	89.8	5.3	92.7	92.9	.2
Apply basic scientific information	88.4	87.6	−.8	40.9	52.9	12	61.7	61.6	−.1
Analyze scientific procedures and data	47.4	48.8	1.4	8.3	12.3	4	19.1	15.5	−3.6
Integrate specialized scientific information	9.9	9.0	−.9	0.6	1.0	.4	2.0	0.5	−1.5
	1979	1984	Difference	1979	1984	Difference	1979	1984	Difference
Writing levels									
Informative writing	89.4	91.3	1.9	72.8	79.5	6.7	78.1	86.1	8
Persuasive writing	62.7	67.2	4.5	52.5	55.7	3.2	46.3	52.9	6.6
Imaginative writing	72.5	76.4	3.9	64.7	68.4	3.7	55.2	76.2	21

(a) Virtually all students were able to perform at this level.

[1] Able to follow brief written directions and select phrases to describe pictures.

[2] Able to understand combined ideas and make references based on short uncomplicated passages about specific or sequentially related information.

[3] Able to search for specific information, interrelate ideas, and make generalizations about literature, science, and social studies materials.

[4] Able to find, understand, summarize, and explain relatively complicated literary and informational material.

[5] Able to understand the links between ideas even when those links are not explicitly stated and to make appropriate generalizations even when the texts lack clear introductions or explanations.

Source: National Center for Education Statistics, "Digest of Education Statistics," 1990.

TABLE 43.—MEAN READING PROFICIENCY SCORES, AND POINT CHANGE, OF 9-, 13-, AND 17-YEAR-OLDS, BY RACE, TYPE OF COMMUNITY, AND PARENTAL EDUCATION: 1971–1984

Variable	9-year-olds			13-year-olds			17-year-olds		
	1971	1984	Change 1971–84	1971	1984	Change 1971–84	1971	1984	Change 1971–84
Race:									
Black	169.3	188.4	19.10	220.3	236.8	16.50	240.6	263.5	22.90
Hispanic	[1] 182.9	193.0	10.10	[1] 231.1	239.2	8.10	[1] 254.7	268.7	14.00
Achievement gap [1] (White-Black)	45.10	31.70	−13.40	39.80	26.60	−13.20	49.80	31.10	−18.70
Type of community:									
Advantaged urban	231.3	231.4	.1	272.4	274.7	2.30	303.5	300.8	−2.70
Disadvantaged urban	177.8	194.4	16.60	232.4	239.6	7.20	259.4	265.9	6.50
Rural	200.7	205.8	5.10	245.0	255.5	10.50	275.8	282.8	6.40
Achievement gap [1] (Adv. Urban-Disadv. Urban)	53.50	37.00	−16.50	40.00	35.10	−4.90	44.10	34.90	−9.20
Achievement gap [1] (Adv. Urban-Rural)	30.60	25.60	−5.00	27.40	19.20	−8.20	27.70	18.00	−9.70
Parental education:									
High school graduates	209.0	211.4	2.40	255.4	253.8	−1.60	282.9	280.6	−2.30
Non-graduates	188.6	197.1	8.50	236.2	241.5	5.30	263.4	269.5	6.10
Post high school	224.7	224.3	−.40	269.7	268.4	−1.30	300.9	300.0	−.90
Achievement gap [1] High school graduates and non-graduates	20.40	14.30	−6.10	19.20	12.30	−6.90	19.50	11.10	−8.40

[1] Data for 1974—not available for 1971.

Source: National Assessment of Educational Progress table from Berlin, Gordon and Andrew Sum. "Toward a More Perfect Union: Basic Skills, Poor Families, and our Economic Future," Occasional Paper 3, Ford Foundation, New York, NY, 1988.

DROPOUT RATES [20]

Recently, concern about dropouts has increased considerably at all levels of society. Each type of dropout rate meaures a different facet of dropping out. Event dropout rates (chart 10 and table 44) measure the proportion of students who leave high school in a single year, without completing it. This measure reveals the number of students dropping out of high school each year and compares each year's rates with those previous years. By contrast, status dropout rates (chart 11 and table 45) measure the proportion of the population, which has not completed high school and which are not enrolled at any single point in time, regardless of when they dropped out. This measure reveals the extent of the dropout problem in the overall population, suggesting the magnitude of the challenge for further training and education. Because they represent the cumulative impact of dropout rates over a number of years, status dropout rates are much higher than event dropout rates.

Trends.—As shown by charts 10 and 11, both status and event dropout rates have been declining over the past 10 years for most groups. Rates have declined for both blacks as well as whites, with steeper declines for blacks. Over the past 15 years, there has been no consistent trend in Hispanic dropout rates (event or status), either upwards or downwards. Throughout the period, Hispanic dropout rates have remained high. For example, between 9 and 11 percent of Hispanic students have dropped out of high school each year.

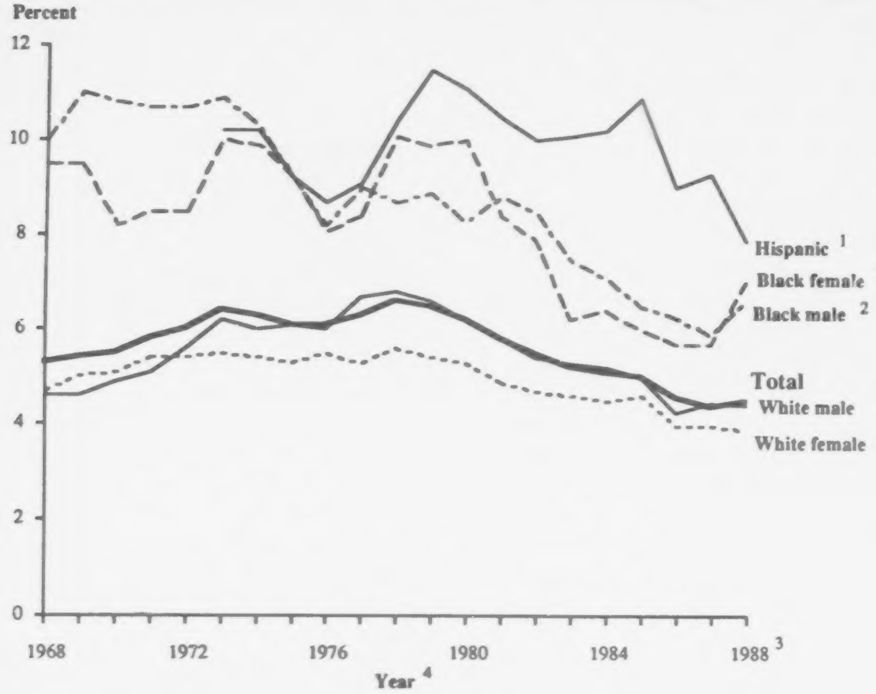
On average, 4.5 percent of 15- to 24-year-olds in grades 10 to 12 (approximately 429,000 students) dropped out of school over the last 3 years (1987 to 1989). For the same period, the event dropout rate was higher in the central cities (6.2 percent) than in suburbs (3.7 percent) or rural areas (4.0 percent). Furthermore, the rates for blacks (6.8 percent) and Hispanics (7.9 percent) were greater than for whites (4.1 percent).

Status rates show that in 1989, approximately 4 million persons in the United States ages 16 to 24 had not completed high school and were not currently enrolled in school. This represented about 12.6 percent of all persons in this age group. The percentage of young persons who are status dropouts has generally declined over the last two decades. In 1968, approximately 16 percent of persons 16 to 24 were not enrolled and had not completed high school, compared with less than 13 percent in 1989.

---

[20] This section draws heavily from "Dropout Rates in the United States: 1988," a report of the National Center for Education Statistics, U.S. Department of Education, September 1990.

CHART 10. THREE-YEAR AVERAGE EVENT DROPOUT RATES FOR GRADES 10–12, AGES 14–24, BY RACE/ETHNICITY, BY SEX: 1968–88



---

[1] Hispanics may be of any race.

[2] Given the relatively large standard errors of these estimates, the apparent increases in black male and female dropout rates between 1986-88 and 1987-89 are *not statistically significant* and may be caused solely by sampling error in the estimates.

[3] Due to a procedural change in CPS, the rate for 1988 is for 15- to 24-year-olds only. The event dropout rate for grades 10-12 is not affected by changing the age group from 14-24 to 15-24.

[4] The year represents the middle of the three years over which rates are averaged. Thus the rate for 1988 is the average of the single-year rates for the 12-month periods ending October 1987, 1988, and 1989.

Note: The moving three-year averages plotted in this figure portray general trends in dropout rates over time. However, the change from one three-year average to the next, i.e. from 1986-88 to 1987-89, should not be interpreted as representing the change from one year to the next, i.e. from 1987 to 1988.

SOURCE: R. Kominski, "Estimating the National High School Dropout Rate," *Demography*, Vol. 27 No. 2, May 1990; U.S. Department of Commerce, Bureau of the Census, "School Enrollment--Social and Economic Characteristics of Students, October (various years)," *Current Population Reports*, Series P-20, and unpublished tabulations.

TABLE 44.—DATA FOR CHART 10: THREE-YEAR AVERAGE EVENT DROPOUT RATES FOR GRADES 10–12, AGES 14–24, BY RACE/ETHNICITY BY SEX: 1968 to 1988

[In percent]

Year [1]	Race/ethnicity and sex				
	White		Black		Hispanic [2]
	Male	Female	Male	Female	
1968	4.6	4.7	10.0	9.5	(†)
1969	4.6	5.0	11.0	9.5	(†)
1970	4.9	5.1	10.8	8.2	(†)
1971	5.1	5.4	10.7	8.5	(†)
1972	5.6	5.4	10.5	8.0	(†)
1973	6.2	5.5	10.9	10.0	10.2
1974	6.0	5.4	10.3	9.9	10.2
1975	6.1	5.3	9.2	9.2	9.2
1976	6.0	5.5	8.2	8.1	8.7
1977	6.7	5.3	9.0	8.4	9.1
1978	6.8	5.6	8.7	10.1	10.4
1979	6.6	5.4	8.9	9.9	11.5
1980	6.2	5.3	8.3	10.0	11.1
1981	5.8	4.9	8.8	8.4	10.5
1982	5.4	4.7	8.5	7.9	10.0
1983	5.3	4.6	7.5	6.2	10.1
1984	5.2	4.5	7.1	6.4	10.2
1985	5.0	4.6	6.5	6.0	10.9
1986 [3]	4.2	4.0	6.2	5.7	9.0
1987	4.4	4.0	5.9	5.7	9.3
1988 [4]	4.4	3.9	6.6	7.0	7.9

† Not available.

[1] The year represents the middle of the 3 years over which rates are averaged. Thus the rate for 1988 is the average of the single-year rates for the 12-month periods ending October 1987, 1988, and 1989.

[2] Hispanics may be of any race.

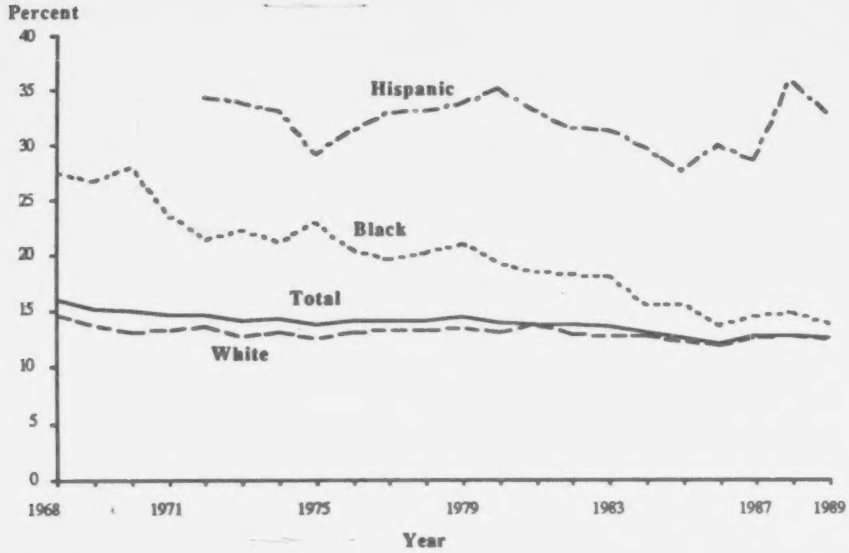
[3] The decline in the 1986 rates in part reflect new editing procedures by the Bureau of the Census for cases with missing data on school enrollment items. The effect of the editing changes for 1986, a bridge year in which the data were edited using both the old and new procedures, was to decrease the single-year event rate from 4.7 percent (old procedure) to 4.3 percent (new procedure). The 3-year rate for 1986 was calculated using 1 year (1985) based on the old editing procedures and 2 years (1986 and 1987) based on the new editing procedures.

[4] The 3-year average for 1988 is based on data for 15- to 24-year-olds only.

Note: Some data different from previously published figures.

Source: R. Kominski, "Estimating the High School Dropout Rate," Demography, Vol. 27, No. 2, May 1990; U.S. Department of Commerce, Bureau of the Census, "School Enrollment—Social and Economic Characteristics of Students, October (various years)," Current Population Reports, Series P–20, and unpublished tabulations.

CHART 11. PERCENTAGE OF STATUS DROPOUTS, AGES 16–24, BY RACE/ETHNICITY: OCTOBER 1968–89



NOTE: Hispanics may be of any race.

SOURCE: U.S. Department of Commerce, Bureau of the Census, "School Enrollment--Social and Economic Characteristics of Students, October (various years)," *Current Population Reports*, Series P-20, and unpublished tabulations.

TABLE 45.—DATA FOR CHART 11: PERCENTAGE OF STATUS DROPOUTS, AGES 16–24, BY RACE/ETHNICITY: OCTOBER 1968 TO 1989

Year	Total	Race/ethnicity		
		White	Black	Hispanic [1]
1968	16.2	14.7	27.4	(†)
1969	15.2	13.6	26.7	(†)
1970	15.0	13.2	27.9	(†)
1971	14.7	13.4	23.7	(†)
1972	14.6	13.7	21.5	34.3
1973	14.1	12.9	22.3	33.7
1974	14.3	13.2	21.3	33.0
1975	13.9	12.6	22.8	29.2
1976	14.1	13.3	20.4	31.3
1977	14.1	13.4	19.7	32.9
1978	14.2	13.4	20.2	33.1
1979	14.6	13.6	21.2	33.8
1980	14.1	13.3	19.3	35.2
1981	13.9	13.8	18.5	33.1
1982	13.9	13.1	18.4	31.7
1983	13.7	12.9	18.1	31.5
1984	13.1	12.7	15.6	29.8
1985	12.6	12.2	15.7	27.6
1986	12.2	12.0	14.1	30.1
1986 [2]	12.1	11.9	13.7	30.0
1987 [2]	12.7	12.5	14.5	28.6
1988 [2]	12.9	12.7	14.9	35.8
1989 [2]	12.6	12.4	13.8	33.0

† Not available.

[1] Hispanics may be of any race.

[2] Numbers for these years reflect new editing procedures instituted by the Bureau of the Census in 1986 for cases with missing data on school enrollment items.

Source: U.S. Department of Commerce, Bureau of the Census, "School Enrollment—Social and Economic Characteristics of Students, October (various years)," Current Population Reports, Series P-20, and unpublished tabulations.

HIGH SCHOOL COMPLETION RATES [21]

Another set of rates, frequently used to derive estimates of dropout rates, are high school completion or graduation rates. A completion rate measures the proportion of some population group which has completed high school. However, it is important to note that an individual who did not complete high school is not necessarily a dropout. Students who, based on their age or grade in a prior year, might be expected to have completed high school may not yet have completed high school and never have been a dropout.

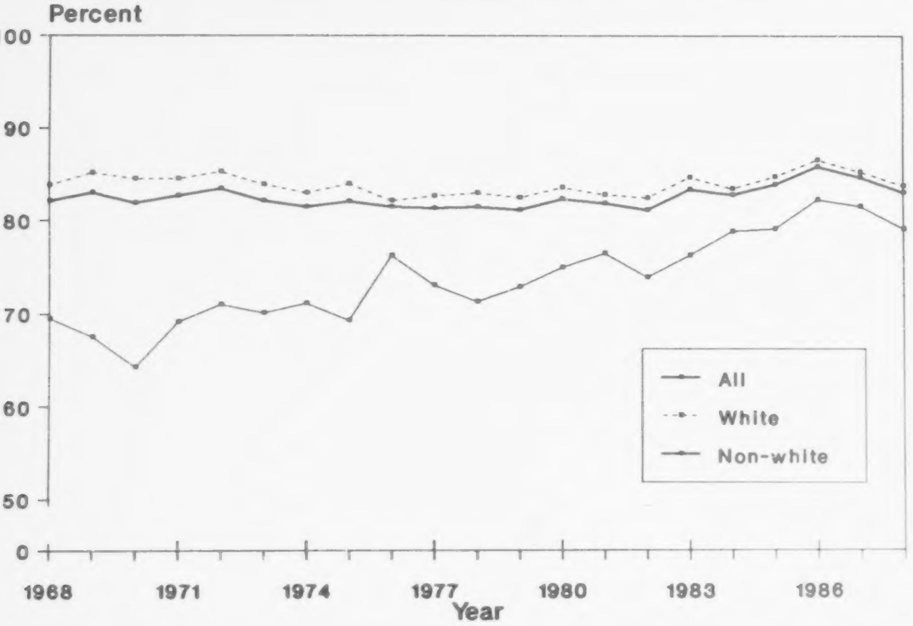
Completion or graduation rates are important in showing what proportion of young people are finishing high school and how long it is taking them to do so. Generally, graduation rates are higher for older age groups (e.g., 20- to 24-year-olds) than for younger ones (e.g., 18- and 19-year-olds). The high school graduation rate is lower if those holding a high school equivalency certificate are not considered high school graduates than if all high school completers, regardless of the method of completion, are counted as graduates.

---

[21] This section borrows heavily from the National Center for Education Statistics, "Dropout Rates in the United States: 1989," September 1990.

Chart 12 and table 46 show the trend over time for the high school completion rate defined as the percentage of persons age 18 to 19 not currently enrolled in high school or below, who have completed high school by receiving a high school diploma or an equivalency certificate. From 1968 to 1982, the rate remained fairly constant at about 82 percent. However, between 1982 and 1989, there was a small but statistically significant increase in the completion rate reaching about 83 percent in 1989. Broken down further by race, the white rate mirrored the trend for all students, while the black rate was significantly lower showing a much less consistent and stable trend.

CHART 12. HIGH SCHOOL COMPLETION RATES FOR 18- AND 19-YEAR-OLDS NOT CURRENTLY IN HIGH SCHOOL OR BELOW; OCTOBER 1968–89



SOURCE: U.S. Department of Commerce, Bureau of the Census, "School Enrollment—Social and Economic Characteristics of Students, October (various years)," Current Population Reports, Series P–20, and unpublished tabulations.

TABLE 46.—HIGH SCHOOL COMPLETION RATES FOR PERSONS 18- AND 19-YEARS OLD NOT CURRENTLY ENROLLED IN HIGH SCHOOL OR BELOW, OCTOBER 1968 TO 1988

[In percent]

Year	High school completion rates		
	All races	White	Nonwhite
1968	82.1	83.8	69.5
1969	83.0	85.2	67.6
1970	81.9	84.5	64.3
1971	82.7	84.5	69.2
1972	83.5	85.3	71.1
1973	82.2	83.9	70.2
1974	81.5	83.0	71.2
1975	82.1	84.0	69.4
1976	81.5	82.2	76.3
1977	81.4	82.7	73.2
1978	81.5	83.0	71.4
1979	81.2	82.5	73.0
1980	82.4	83.6	75.1
1981	81.9	82.8	76.6
1982	81.2	82.5	74.0
1983	83.4	84.7	76.4
1984	82.8	83.5	78.9
1985	83.9	84.8	79.2
1986*	85.9	86.6	82.3
1987*	84.7	85.3	81.6
1988*	83.1	83.8	79.2

*Numbers for these years reflect new editing procedures instituted by the Bureau of the Census in 1986 for cases with missing data on school enrollment items.

Note: Non-white persons include blacks, American Indians, Japanese, Chinese, other Asians and Pacific Islanders, and any other race except White, Hispanics, not shown separately in this table, may be of any race.

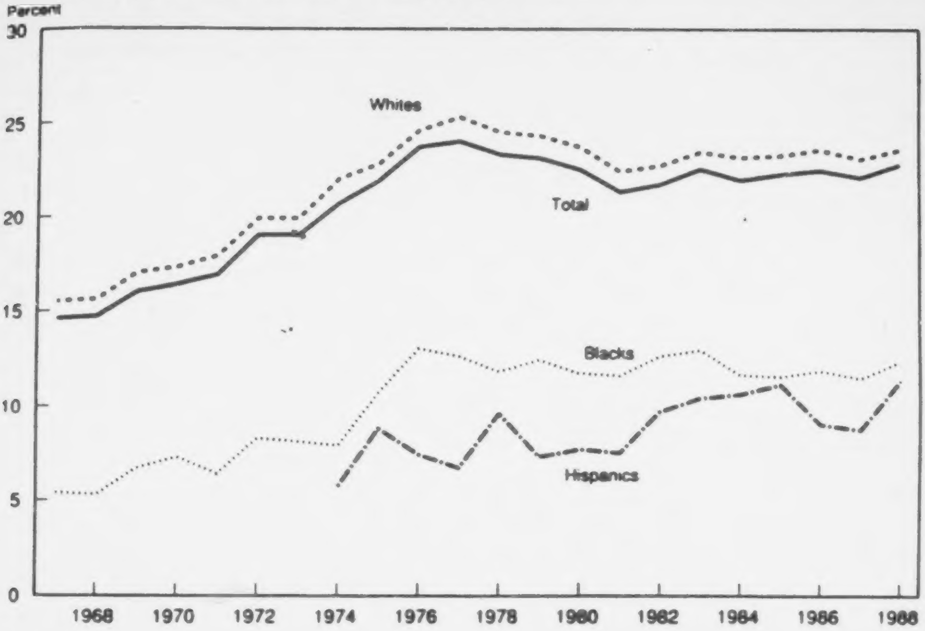
Source: U.S. Department of Commerce, Bureau of the Census, "School Enrollment—Social and Economic Characteristics of Students, October (various years)," Current Population Reports, Series P–20, and unpublished tabulations.

COLLEGE COMPLETION RATES

Since the early 1980's, the proportion of 25- to 29-year-olds completing 4 or more years of college has remained virtually unchanged, at about 22 percent of the young adult population (see chart 13). Of minority groups, only 12 percent of young blacks and 11 percent of young Hispanics complete 4 or more years of college.

CHART 13. COLLEGE COMPLETION RATES BY RACE

After rising through the mid-1970', the percent of young adults completing 4 or more years of college fell in the late 1970's and leveled off in the 1980's



NOTE: Data are percent of 25- to 29-year-olds who have completed 4 or more years of college
SOURCE: U.S. Department of Commerce, from Economic Report of the President, 1990

LABOR FORCE PARTICIPATION OF MOTHERS [22]

Trends in the labor force participation of mothers

A person is defined as participating in the labor force if he or she is working or seeking work. Table 47 shows the labor force participation rates of women with children for selected years between 1947 and 1987, by age of the mother's youngest child. In 1947, just following World War II, nearly 70 percent of all mothers with children between the ages of 6 and 17 were outside the labor force. Today, over 70 percent of such mothers are labor force participants. The increased labor force participation of mothers with younger children has also been dramatic. In 1947, it was unusual to find mothers with a preschool-age child in the labor force (only about 12 percent of all mothers with children under the age of 6 were in the labor force at that time) Today it is the norm. In 1987, nearly 60 percent of mothers with preschool-age children were in the labor force, a rate between 4 and 5 times higher than in 1947. Women with infant children have become increasingly engaged in the labor market as well. Today, over half of all mothers whose youngest child is under age 2 are in the labor market, while in 1975 less than one-third of all such mothers were labor force participants.

---

[22] This section borrows heavily from a CRS report to Congress entitled "Child Day Care: Patterns of Use Among Families With Preschool Children," by Thomas Gabe and Sharon Stephan, December 19, 1988, and a Department of Commerce report entitled "Women in the Work Force," Bureau Series P-23, No. 146, November 1986.

Single mothers with children represent a greater share of all families with children today than in the past; they also represent a larger share of the labor force today than ever before. Compared to married mothers with children, the labor force participation of single mothers (especially divorced mothers) has always been high. Nonetheless, the labor force participation of single mothers with preschool-age children has generally continued to increase over recent years (see table 48). Married mothers with young children have especially increased their labor involvement in recent years, with rates of labor force participation approaching, and in some cases exceeding, those of single mothers.

TABLE 47.—LABOR FORCE PARTICIPATION RATES OF WOMEN, BY PRESENCE AND AGE OF YOUNGEST CHILD, SELECTED YEARS, 1947–87

	No children under 18	With children under age 18				
		Total	Age 6 to 17 only	Under age 6		
				Total	Under 3	Under 2
April 1947	29.8	18.6	27.3	12.0	N/A	N/A
April 1950	31.4	21.6	32.8	13.6	N/A	N/A
April 1955	33.9	27.0	38.4	18.2	N/A	N/A
March 1960	35.0	30.4	42.5	20.2	N/A	N/A
March 1965	36.5	35.0	45.7	25.3	21.4	N/A
March 1970	42.8	42.4	51.6	32.2	27.3	N/A
March 1975	45.1	47.3	54.8	38.8	34.1	31.5
March 1980	48.1	56.6	64.3	46.8	41.9	39.2
March 1981	48.7	58.1	65.5	48.9	44.3	42.0
March 1982	48.6	58.5	65.8	49.9	45.6	43.3
March 1983	48.7	58.9	66.3	50.5	46.0	44.5
March 1984	49.3	60.5	68.1	52.1	47.6	46.4
March 1985	50.4	62.1	69.9	53.5	49.5	48.0
March 1986	50.5	62.8	70.4	54.4	50.8	49.2
March 1987	50.5	64.7	72.0	56.7	52.9	51.9

Source: U.S. Department of Labor. Bureau of Labor Statistics. Unpublished data, courtesy of Howard Hayge.

Although the labor force is proportionately populated more by women and mothers today than in the past, today's labor force has proportionately fewer workers with children than in years past. While the representation of women and mothers in the labor force has increased over the last several decades, the proportion of the labor force, male or female, who have children residing with them at home is actually smaller today than in past years. In 1968, 44.2 percent of labor force participants had a child under age 18 living in the home, whereas only 38.5 percent had a child in 1985. However, a greater proportion of all workers with children today, than in the past, are mothers. As mothers, these workers have traditionally been the principal caretakers of their children. In addition, a greater proportion of working men with children today than in the past have a spouse who is working outside the home. In 1977, both the husband and wife worked in slightly over half (51.8 percent) of all married-couple families with children; in 1987, husbands and wives both worked in two-thirds (66.8 percent) of all such families.

TABLE 48.—LABOR FORCE PARTICIPATION RATES OF WOMEN WITH CHILDREN, BY MARITAL STATUS AND AGE OF YOUNGEST CHILD, MARCH OF SELECTED YEARS

[In percent]

	1960	1970	1980	1986	1987	1988	Percent increase, 1970–88
All women with children	[1] 30.4	[1] 52.9	56.6	62.8	64.7	65.0	22.9
Married women:							
Youngest under 6	18.6	30.3	45.0	53.8	56.8	57.1	88.4
Youngest 6 or over	39.0	49.2	61.8	68.4	70.6	72.5	47.4
Separated women:							
Youngest under 6	NA	45.4	52.2	57.4	55.1	53.0	16.7
Youngest 6 or over	NA	60.6	66.6	70.6	72.6	69.3	14.3
Divorced women:							
Youngest under 6	NA	63.3	68.3	73.8	70.5	70.1	10.7
Youngest 6 or over	NA	82.4	82.3	84.7	84.5	83.9	1.8
Never-married women:							
Youngest under 6	NA	NA	44.1	47.5	49.9	44.7	NA
Youngest 6 or over	NA	NA	67.6	65.9	64.1	67.1	NA

[1] Excludes never-married women.

Source: "The Welfare Reform Debate As It Will Confront The Next President" by Robert D. Reischauer, The Brookings Institution, February 1988. Data from the Department of Labor, Bureau of Labor Statistics, News Release USDL 88-431, September 7, 1988; Bureau of the Census, Statistical Abstract of the United States, 1987, Table 654 and Department of Labor Bulletin No. 2175, Table 56, page 125; B.L.S. News Release USDL 86-345, August 20, 1986, USDL 84-321, July 26, 1984, USDL 87-345 August 12, 1987, Table 3; and Department of Labor, BLS, Special Labor Force Report, Marital and Family Characteristics of Workers, March 1960, April 1961, Table G.

Mother's attachment to the labor force, as expressed by their labor force participation rates, and full or part-time employment rates, differ depending upon the age of their youngest child and marital status, as tables 48 and 49 show.

Table 49 provides a detailed breakdown of the labor force participation of women for March of 1988, by marital status and the age of the youngest child. Among those with children under 18, divorced women have the highest labor force participation rates, followed by married and separated women. Widowed and never-married women have lower labor force participation rates.

As this table illustrates, no matter what the marital status of the woman, labor force participation rates tend to increase as the age of the youngest child increases. For example, among all women with children under 18, 53 percent of those with a child under 3 participate, 62 percent of those whose youngest child is between 3 and 5 participate, and 73 percent of those whose youngest child is between 6 and 17 participate.

TABLE 49.—LABOR FORCE PARTICIPATION RATES OF WOMEN WITH CHILDREN UNDER 18, MARCH 1988, BY MARITAL STATUS AND AGE OF YOUNGEST CHILD

	Age of youngest child						
	Under 3	Under 6	Under 18	3 to 5	6 to 13	6 to 17	14 to 17
All women with child under 18	52.5	56.1	65.0	61.4	72.7	73.3	74.5
Married, spouse present	54.5	57.1	65.0	61.2	72.2	72.5	73.0
Divorced	62.8	70.1	80.1	73.7	82.3	83.9	87.1
Separated	48.6	53.0	61.7	58.9	68.1	69.3	72.2
Widowed	(1)	43.8	59.5	43.8	53.5	62.5	71.8
Never-married	40.1	44.7	51.6	53.9	63.6	67.1	60.8

[1] Data not shown where base is less than 75,000.

Source: Department of Labor, Bureau of Labor Statistics, USDL 88–431, September 7, 1988.

While there has been a substantial increase in the proportion of mothers in the labor force, the data can be misleading. Although 65 percent of mothers participated in the labor force in 1986, as table 49 shows, 44 percent worked full time, 16 percent worked part time, and 5 percent were actively seeking a job. (Full time work is defined as 35 or more hours per week; part time work is defined as 34 hours or less.) Thirty-six percent of mothers with children under age 6 worked full time, and 18 percent worked part time.

Note that even these numbers can be misleading. "Full time" means full time for any period during the calendar year, and not necessarily full time for the full year. "Part time" means anything from a few hours a week during the Christmas season up to 34 hours a week year round. Only 29 percent of married mothers worked full time for a full year in 1986. An additional 8 percent of them worked full time 27 to 49 weeks a year; 7 percent worked full time from 1 to 26 weeks a year (these data do not appear in the table).

As table 50 demonstrates, how much mothers work differs according to their marital status and the age of their children. Forty-three percent of married women with children worked full time; thus, close to 60 percent either didn't work at all or worked part-time. Some 66 percent of all divorced mothers worked full time; 54 percent of divorced mothers with children under 6 worked full time. Only 32 percent of never-married mothers worked full time, and only 8 percent worked part time.

TABLE 50.—FULL- OR PART-TIME[1] EMPLOYMENT STATUS OF MOTHERS BY MARITAL STATUS AND AGE OF YOUNGEST CHILD, MARCH 1988

[In percent]

	With children under 18	With children under 6
All mothers:		
Employed full time	44	36
Employed part time	16	16
Married, spouse present:		
Employed full time	43	36
Employed part time	19	18
Divorced:		
Employed full time	66	54
Employed part time	9	9
Never married:		
Employed full time	32	26
Employed part time	8	7

---

[1] Full-time workers work 35 hours or more per week, part-time workers work 1 to 34 hours a week.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Table 51 presents data for 1977, 1982 and 1987 on the percent of children under 18 with a mother in the labor force, by various family types. In 1987, 60 percent of all children under 18 had a mother in the labor force, compared with 48 percent in 1977. Of all children under age 6, 53 percent had a mother in the labor force in 1987, compared with 38 percent in 1977.

TABLE 51.—PERCENT OF OWN CHILDREN UNDER 18 YEARS OLD WITH A MOTHER IN THE LABOR FORCE, BY FAMILY TYPE, MARCH 1977, 1982, AND 1987

[Numbers in thousands]

Age of children and family type	1977	1982	1987
Total children under 18 years old	47.7	54.9	60.2
6 to 17 years	51.7	59.1	63.8
Under 6 years	37.6	45.8	53.1
In married-couple families	46.4	54.3	61.3
6 to 17 years	50.5	58.7	65.1
Under 6 years	36.6	45.5	54.4
In families maintained by women	58.4	62.7	63.5
6 to 17 years	62.4	66.8	67.8
Under 6 years	45.7	51.2	53.0

Source: Bureau of Labor Statistics.

CHILD CARE

Because of the huge increase in the number of employed mothers, child care has become an important issue. As noted in the previous subsection, the majority of all children now have a mother who works either full- or part-time, or is actively seeking work. This section presents data on the child care arrangements of children under age 15 with working mothers, on the numbers and types of childcare facilities, on employers' child care practices and policies, and a description of the Federal role in child care.

PRIMARY CHILD CARE ARRANGEMENTS BY MARITAL AND EARNINGS STATUS OF THE MOTHER [23]

"Primary child care arrangement" refers to the arrangement used most frequently during a typical work week. Table 52 shows the distribution of the primary child care arrangements provided for preschoolers (children under 5 years old) and grade-school-age children (5 to 14 years old) during the Fall of 1987, by marital and work status of the employed mother.

This table illustrates that of the 9.1 million preschool-age children of working women, 24 percent received organized care in day care centers or preschools most of the time their mothers were at work. The remainder were primarily supervised by relatives (45.9 percent) or a family day care provider (22.3 percent). About 71 percent of the 19.7 million grade school children were in school most of the hours their mothers were at work. An additional 19 percent were cared for by relatives.

Considerably different patterns of child care usage are also noted depending on the weekly work schedule and marital status of the mother, as table 52 shows.

SECONDARY CHILD CARE ARRANGEMENTS

"Secondary child care arrangement" refers to the arrangement used second most frequently during a typical work week. Almost 8 million children, or 28 percent of all children under age 15, used a secondary child care arrangement during the fall of 1987. Secondary child care arrangements are used by 35 percent of school-age children 5 to 14 years old, but by only 12 percent of children under 5 years.

The types of secondary child care arrangements used by school-age children who are in school most of the time their mothers are at work are shown in table 53. The most frequently mentioned secondary care arrangement for older children whose mothers are employed is relative care (49.9 percent). Another 21.6 percent care for themselves, while 12.4 percent attend family day care.

---

[23] This and the following subsection borrow heavily from "Who's Minding the Kids? Child Care Arrangements, Winter 1984-85," U.S. Department of Commerce, Bureau of the Census, Series P-70, No. 9, May 1987; and "Who's Minding the Kids? Child Care Arrangements, Winter 1986-87," U.S. Dept. of Commerce, Bureau of the Census, Series p-70, No. 20, July 1990. Data on the child care arrangements of working mothers are based on the Survey of Income and Program Participation (SIPP).

TABLE 52.—PRIMARY CHILD CARE ARRANGEMENTS OF CHILDREN UNDER 15 WITH AN EMPLOYED MOTHER, BY MARITAL AND EMPLOYMENT STATUS OF THE MOTHER, FALL 1987

[Percent]

Marital status of mother and type of arrangement	Children under 5 years			Children 5 to 14 years		
	Total	Full time	Part time	Total	Full time	Part time
Children of employed mothers (thousands)	9,124	5,677	3,447	19,718	12,943	6,775
All marital statuses:						
Relative care [1]	45.9	38.6	58.0	18.8	16.6	23.7
Family day care [2]	22.3	25.0	17.6	2.3	2.4	2.1
Organized care [3]	24.4	28.4	17.6	2.3	2.6	1.9
School care [4]	1.0	1.4	0.4	71.1	72.2	69.0
Other [5]	6.5	6.5	6.4	5.5	6.5	3.6
Married, husband present:						
Relative care [1]	47.4	38.9	60.3	19.3	16.5	23.7
Family day care [2]	22.2	25.3	17.6	1.9	2.1	1.8
Organized care [3]	23.4	28.1	16.5	2.4	2.7	2.0
School care [4]	0.9	1.3	0.3	71.9	73.4	69.5
Other [5]	6.1	6.4	5.5	4.4	5.4	3.0
All other marital statuses: [6]						
Relative care [1]	39.3	37.5	44.0	17.6	16.2	22.6
Family day care [2]	22.3	24.0	18.2	3.3	3.1	3.7
Organized care [3]	28.3	29.7	24.8	2.1	2.4	1.0
School care [4]	1.4	1.7	0.6	68.5	69.2	66.1
Other [5]	8.7	7.2	12.5	8.4	9.0	6.5

---

[1] "Relative care" includes care in the child's home by a father or other relative, care in another home by a relative, and care provided by the mother while working at home or away from home.

[2] "Family day care" is care provided in another home by a nonrelative.

[3] "Organized care" includes day group care centers and nursery and preschools.

[4] School care includes kindergarten and grade school.

[5] "Other" includes caring for self, and care by a nonrelative in the child's home.

[6] Includes "married, husband absent" (including separated), "widowed," "divorced," and "never-married" women.

Source: Derived from "Who's Minding the Kids? Child Care Arrangements: Winter 1986–87," U.S. Department of Commerce, Bureau of the Census, Series P–70, No. 20, July 1990.

Note: Totals may not add due to rounding.

TABLE 53.—SECONDARY CHILD CARE ARRANGEMENTS FOR CHILDREN 5 TO 14 WHO ARE IN SCHOOL MOST OF THE TIME WHILE THEIR MOTHERS ARE AT WORK, FALL, 1987

[Percent]

Type of child care arrangement	Total
Number of children (in thousands)	5,977
Relative care [1]	49.9
Family day care [2]	12.4
Organized care [3]	10.3
School care [4]	1.4
Child cares for self	21.6
Other [5]	4.5

---

[1] "Relative care" includes care in the child's home by a father or other relative, care in another home by a relative, and care provided by the mother while working at home or away from home.

[2] "Family day care" is care provided in another home by a nonrelative.

[3] "Organized care" includes day/group care centers and nursery and preschools.

[4] "School care" includes kindergarten and grade school.

[5] "Other" includes care by a nonrelative in the child's home.

Note: Totals may not add due to rounding.

Source: "Who's Minding the Kids? Child Care Arrangements: Fall 1986-87," U.S. Department of Commerce, Bureau of the Census, Series P-70, No. 20, July 1990.

TABLE 54.—PRIMARY CHILD CARE ARRANGEMENT OF YOUNGEST PRESCHOOL-AGE CHILD FOR FAMILIES IN WHICH THE MOTHER WORKS, BY RATIO OF FAMILY INCOME TO THE POVERTY THRESHOLD, WINTER 1984–85

	Total	Ratio of family income to the poverty threshold				
		Less than 1.00	1.00 to 1.99	2.00 to 2.99	3.00 to 3.99	4.00 and above
All mother-present families:						
Total (number in 1,000s)	6,311	552	1,528	1,760	1,031	1,440
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Relative care [1]	38.4	47.8	50.5	40.2	30.6	25.5
Family day care	22.9	21.5	14.6	22.4	28.0	29.2
Organized care [2]	24.8	17.6	21.4	23.1	29.5	30.1
Other:						
At-home sitter [3]	5.5	2.6	3.1	5.3	4.7	10.1
Mother's care [4]	8.3	10.6	10.4	9.0	7.2	5.1
Married-couple families:						
Total (number in 1,000s)	5,089	221	1,050	1,468	987	1,364
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Relative care [1]	38.2	50.2	55.5	40.1	31.2	25.6
Family day care	22.3	11.8	12.1	21.7	27.5	28.7
Organized care [2]	23.9	13.5	15.2	22.8	28.8	30.0
Other:						
At-home sitter [3]	6.2	4.1	3.7	5.0	4.9	10.6
Mother's care [4]	9.5	20.6	13.5	10.3	7.5	5.0
Single female-headed families:						
Total (number in 1,000s)	1,222	331	478	292	44	76
Percent	100.0	100.0	100.0	100.0	NA	NA
Relative care [1]	39.8	46.2	39.5	40.6	NA	NA
Family day care	25.4	28.0	20.1	25.9	NA	NA
Organized care [2]	28.5	20.3	35.0	24.0	NA	NA
Other:						
At-home sitter [3]	2.8	1.6	1.9	6.8	NA	NA
Mother's care [4]	3.4	4.0	3.5	2.7	NA	NA

---

[1] Includes a small number of children who are cared for by siblings.

[2] Includes a small number of children enrolled in school.

[3] Care by a nonrelative in the child's home.

[4] The mother cares for the child while she works, either at home, or away from home at her place of employment.

NA—Estimates not available. Sample size is considered too small for reliable estimates.

Note: Details may not sum to totals due to rounding. Data reflect primary child care arrangements used by families for their youngest preschool age child (children under age 5) when the mother works. Mothers' employment status is based on the month preceding the survey. Family income to poverty ratios are based upon families' incomes for the month prior to the interview, compared to families' poverty thresholds. Monthly poverty estimates overstate official annual estimates, somewhat.

Source: Derived from table prepared by the Congressional Research Service (CRS). Estimates are based on data from the Survey of Income and Program Participation (SIPP) Wave V, covering the winter of 1984–85.

TABLE 55.—EMPLOYMENT STATUS AND USE OF PAID CHILD CARE, BY MOTHERS WITH A PRESCHOOL-AGE CHILD, BY THE RATIO OF FAMILY INCOME TO THE POVERTY THRESHOLD AND FAMILY TYPE, WINTER 1984–85

Family type and ratio of family income to the poverty threshold	Percent working	Percent of those working paying cash for child care
All mother-present families:		
Total	48.6	57.2
Less than 1.00	19.9	41.9
1.0 to 1.99	44.1	47.9
2.0 to 2.99	59.1	55.2
3.0 to 3.99	60.7	64.5
4.0 and over	68.9	70.1
Married-couple families:		
Total	50.3	55.9
Less than 1.00	19.4	26.5
1.0 to 1.99	38.4	41.1
2.0 to 2.99	55.9	52.7
3.0 to 3.99	61.7	63.6
4.0 and over	67.7	69.9
Single female-headed families:		
Total	42.3	62.4
Less than 1.00	20.3	52.2
1.0 to 1.99	65.6	62.6
2.0 to 2.99	83.2	67.7
3.0 to 3.99	NA	NA
4.0 and over	NA	NA

NA—Estimates not available. Sample size is considered too small for reliable estimates.

Note: Estimates of the number of families purchasing child care are for those families in which the mother worked and that had a child of preschool age (under age 5) in a primary or secondary child care arrangement in which payment is possible (child cared for by someone other than a parent or sibling). Estimates are for only those families that spent money on child care. Mothers' employment status is based on the month preceding the survey. Family income to poverty ratios are based upon families' incomes for the month prior to the interview, compared to families' poverty thresholds. Monthly poverty estimates overstate official annual estimates, somewhat.

Source: Table prepared by the Congressional Research Service (CRS). Estimates are based on data from the Survey of Income and Program Participation (SIPP) Wave V, covering the winter of 1984–85.

TABLE 56.—TYPICAL WEEKLY AMOUNT SPENT ON CHILD CARE FOR MOTHER–PRESENT FAMILIES WITH PRESCHOOL–AGE CHILDREN WHO SPENT MONEY ON CHILD CARE, BY RATIO OF FAMILY INCOME TO THE POVERTY THRESHOLD AND BY FAMILY TYPE

Ratio of family income to poverty	Number of families (in 1,000s)	Dollars spent			Percent of mother's earnings			Percent of family income		
		Bottom quartile	Median	Top quartile	Bottom quartile	Median	Top quartile	Bottom quartile	Median	Top quartile
A. By ratio of family income to the poverty threshold:										
Total	3,607	$25	$40	$50	11.4	15.7	22.9	4.3	6.2	10.0
Less than 1.00	231	20	25	35	18.8	28.6	46.7	11.1	19.9	34.5
1.00 to 1.99	731	20	35	45	13.1	17.8	26.7	6.6	10.4	13.9
2.00 to 2.99	971	25	38	50	12.5	17.4	26.4	5.0	6.9	9.9
3.00 to 3.99	664	30	40	50	10.9	14.6	21.3	4.2	5.6	7.5
4.00 and over	1,008	35	50	70	9.2	12.9	17.4	3.2	4.4	6.0
B. By family type:										
All mother-present families	3,607	25	40	50	11.4	15.7	22.9	4.3	6.2	10.0
Married-couple families	2,844	28	40	55	11.2	15.4	22.9	4.0	5.6	8.3
Single female-headed families	763	25	35	50	12.3	16.7	23.1	6.6	12.0	17.0

Note: Data reflect typical weekly amount spent on child care by families in which the mother worked and that have a child of preschool age (under age 5) who is in a primary or secondary child care arrangement in which payment is possible (child cared for by someone other than a parent or sibling). Estimates are for only those families that spent money on child care. Estimates are for the total amount spent by families on child care, not just for the care of the youngest preschool age child. Mothers' employment status is based on the month preceding the survey. Family income to poverty ratios are based upon families' incomes for the month prior to the interview, compared to families' poverty thresholds. Monthly poverty estimates overstate official annual estimates, somewhat.

Source: Table prepared by the Congressional Research Service (CRS). Estimates are based on data from the Survey of Income and Program Participation (SIPP) Wave V, covering the winter of 1984–85.

CHILD CARE FACILITIES

There are no national data on the number, types, or quality of child care facilities in the United States. A Children's Defense Fund (CDF) survey of State lists of regulated child care centers found 71,645 such centers with an estimated capacity of 3.8 million slots, as of June 1990. Researchers estimate that approximately 62 percent of listed centers—or 44,419 centers—are actually operating, with an estimated capacity of 2.4 million slots.[24] Estimates of the number of family day care homes vary. CDF's survey found 193,319 regulated homes, with an estimated capacity of 966,003 slots. A survey by the Children's Foundation identified 223,351 regulated family day care homes in 1990. It is generally assumed that the number of regulated family child care providers represents a small percentage of the total number of such providers (some estimates place it at less than 10 percent). In general, the number of regulated facilities is probably far below the total number of child care facilities that are in operation. Counts of regulated facilities do not take into account facilities that may be exempt from regulation (such as some school- and church-sponsored programs), registered facilities (such as family child care homes), and facilities operating illegally.

EMPLOYER CHILD CARE PRACTICES [25] [26]

As table 57 indicates, about 2 percent, or 25,000, of the Nation's establishments (both private industry and government) with 10 employees or more sponsor day care centers for their workers' children. Three percent, or 35,000 establishments provide financial assistance to be used specifically for child care. Overall, 11 percent of these establishments provide some specific benefits or services to workers for their child care arrangements. In addition to sponsoring centers or providing financial assistance, these services include counseling, referral, and the provision of information about local child care.

Child care practices vary with the size of the establishment. As table 57 shows, among those establishments with 250 employees or more, about 5 percent actually sponsor day care centers and 9 percent assist their employees with child care expenses. Much smaller proportions of medium-sized firms (50 to 249 employees) and small-sized firms (10 to 49 employees) provide such benefits. Altogether, 32 percent of the largest establishments, compared with only 9 percent of the smallest, provide some child care benefits or services.

As table 57 also indicates, government agencies are much more likely than firms in private industry to sponsor child care, even if one controls for the size of the establishment. Overall, about 9 percent of government offices (including Federal, State, and local agencies) actually sponsor day care centers for their workers' children. Among private firms, the comparable proportion was less than 2 percent. Government agencies are also much more likely to provide their employees with child care information, referral and counseling services. Overall, private firms are equally as likely as government agencies to assist their employees with child care expenses (3.1 percent and 2.9 percent, respectively). However, if one controls for the size of the establishment, medium- and large-sized private firms are roughly twice as likely to assist with child care expenses.

---

[24] See methodology described in "Day Care Centers: 1976–1984 Has Supply Kept Up With Demand," by William R. Prosser, Social Services Technical Analysis Paper, U.S. Department of Health and Human Services, May 1986.

[25] This subsection borrows heavily from "BLS Reports on Employer Child-Care Practices," Bureau of Labor Statistics, U.S. Department of Labor, USDL 88–7, January 15, 1988.

[26] For more information on specific Federal Government programs for Federal employees, see "Child Day Care: Funding Under Selected Programs," by Susan Schillmoeller and Sharon Stephan, CRS, November 1, 1988.

TABLE 57.—TYPE OF CHILD-CARE BENEFITS PROVIDED BY ESTABLISHMENTS WITH 10 EMPLOYEES OR MORE, BY TYPE AND SIZE OF ESTABLISHMENT, SUMMER 1987

Type of establishment and child care benefits	Establishments with 10 employees or more			
	Total	10 to 49 employees	50 to 249 employees	250 employees or more
Total establishments (thousands)	1,202	919	236	47
Percent providing child-care benefits or services	11.1	9.0	15.3	31.8
Employer-sponsored day care	2.1	1.9	2.2	5.2
Assisted with child-care expenses	3.1	2.4	4.7	8.9
Child-care information and referral services	5.1	4.3	6.3	14.0
Counseling services	5.1	3.8	7.6	17.1
Other child-care benefits	1.0	.7	1.6	2.9
Private sector establishments (thousands)	1,128	879	213	36
Percent providing child-care benefits or services	10.1	8.3	14.1	31.6
Employer-sponsored day care	1.6	1.5	1.8	2.7
Assisted with child-care expenses	3.1	2.4	4.9	10.3
Child-care information and referral services	4.3	3.6	5.5	14.6
Counseling services	4.2	3.1	6.5	17.0
Other child-care benefits	.9	.7	1.5	2.7
Government establishments (thousands)	74	40	23	11
Percent providing child-care benefits or services	26.4	24.1	27.2	32.7
Employer-sponsored day care	9.4	10.2	6.1	13.2
Assisted with child-care expenses	2.9	2.5	2.8	4.3
Child-care information and referral services	15.8	17.9	14.1	12.0
Counseling services	18.2	18.6	17.9	17.4
Other child-care benefits	2.3	1.5	2.9	3.7

THE FEDERAL ROLE [27]

Numerous Federal programs provide assistance for child care services, training for child care providers, and related activities. Most of these programs are not child care programs per se, but support child care as a component of programs supporting other activities, such as job training, housing assistance, education, food stamps, nutrition assistance, and other kinds of services. New programs aimed specifically at providing child care services were enacted at the end of the 101st Congress, as part of the fiscal year 1991 Omnibus Budget Reconciliation Act (P.L. 101-508), which include new State grant programs and Tax Code amendments. The enactment of these programs followed 4 years of intense debate over the nature and extent of the nation's child care programs and the Federal options for alleviating them.

---

[27] This section is based on an update of information provided in "Child Day Care: Funding Under Selected Programs," by Susan Schillmoeller and Sharon Stephan, CRS, Nov. 1, 1988.

Federal funding for child care services provided under many of these programs is unknown or estimated. The total number of children receiving federally supported child care assistance is also unknown. Below is a brief description of major Federal programs that support child care and related activities.

Federal assistance for child care

- —The child and dependent care tax credit, authorized under section 21 of the Internal Revenue Code, provides the largest federal support in the area of child care. The support is indirect, available to taxpayers who work or are seeking work, in the form of a nonrefundable tax credit. It is indexed according to both income and number of dependents, and is applicable to a limited amount of employment-related child care expenses. The estimated revenue loss for this tax credit in fiscal year 1991 is $4.2 billion. See part 1, section 12, for a more complete description of this tax credit.
- —The Child Care and Development Block Grant, authorized by Public Law 101-508, provides grants to States for child care services and activities to improve the availability and quality of child care. Children are eligible for services if they are under age 13, have at least one working parent, and have family incomes less than 75 percent of the State median income. The fiscal year 1991 appropriation for the program is $731.9 million, to be available for obligation on September 7, 1991.
- —Public Law 101-508 authorized a child care grant program as an amendment to Title IV-A of the Social Security Act. The program is a "capped entitlement" under which States are entitled to matching funds for child care expenditures, up to State limits determined by formula. The fiscal year 1991 appropriation is $300 million. The program is referred to as the "at-risk" child care program because families are eligible for child care if they need child care in order to work and are at risk of becoming eligible for AFDC.
- —Public Law 101-508 also authorized a "Supplemental Young Child Credit" as an amendment the Earned Income Tax Credit Program. The additional 5 percent credit is available to eligible families with a child under age 1.
- —The Social Services Block Grant Program is authorized under title XX of the Social Security Act and provides grants to States for activities determined by the States to be appropriate social services. Typical activities include child care. The fiscal year 1991 appropriation for all title XX services was $2.8 billion. See section 10 of part 1 for a more complete description of title XX.

—Section 129 of the Internal Revenue Code, as amended by the Tax Reform Act of 1986, allows employees with children under age 15 or disabled dependents or spouses to exclude from their gross income qualified employment-related dependent care assistance paid for or provided by their employers. The estimated tax revenue loss for fiscal year 1990 equaled $240 million.

—The Food Stamp Program allows recipients to deduct up to $160 a month per dependent for dependent care expenses related to work, education and training. During the winter of 1988, 179,000 households (2.5 percent of all households receiving food stamps) claimed the dependent care deduction. The average amount claimed was $97 per month.

—The AFDC Program, authorized under the Social Security Act, requires that States deduct child or dependent care expenses (up to $175 per month per child age 2 or more, and up to $200 per month per child less than age 2) from the earned income of a working family in determining the assistance level. In 1988, 1.7 percent of AFDC families (about 65,000 families) deducted child or dependent care expenses from their earned income. The average deduction was $114.

—Under title II of the Perkins Act, child care services may be provided to students in vocational education programs either as a support service or to make the programs more accessible.

—Students may count a certain portion of child care expenses as part of the total cost of postsecondary education and thereby receive Federal student aid to cover part of those costs beginning in fiscal year 1988 through the various Federal grant and loan programs administered by the Department of Education and authorized under the Higher Education Amendments of 1986.

—Under the AFDC JOBS program, authorized by the Family Support Act of 1988, States are required to guarantee child care to the extent it is necessary for employment, or for education and training activities, and provide "transitional" child care assistance to families who cease to receive public assistance because of work or earnings.

—Under the United States Housing Act of 1937, as amended by the Housing and Community Development Act of 1987, child care expenses, to the extent they are necessary to enable a family member to work or go to school, may be deducted in determining adjusted income under the Public Housing and section 8 housing programs. It is estimated that less than 2 percent of families in public housing use the child care deduction and that less than 2 percent of families participating in the section 8 program use the child care deduction. Estimated outlays in fiscal year 1988 for day care under these two programs equaled $18 million.

—The JTPA Program (authorized under title II–A of the Job Training Partnership Act of 1982) allows up to 15 percent of funds to be spent on a variety of supportive services including child care. At local discretion, individuals may be trained as child care workers or child care may be provided as a supportive service to participants in training.

- —The Dependent Care Planning and Development Program, authorized under the Augustus Hawkins Human Services Reauthorization Act of 1990, authorizes 75 percent matching grants to States for dependent care services before and after school and for establishing or expanding local resource and referral systems (fiscal year 1991 appropriations equaled $13.2 million). Temporary Child Care for Handicapped Children and Crisis Nurseries (authorized under title II of the Children's Justice Act), authorizes 75 percent Federal matching grants to States to provide temporary care for handicapped children and children with chronic illnesses, and crisis nurseries and referrals for abused and neglected children (fiscal year 1991 appropriations equaled $11.1 million).
- —The Federal Government also operates several programs which seek to train day care workers, support employers, and assist providers (Child Development Associate (CDA) scholarships, tax deductions for child care as a business expense, guaranteed loans for small businesses (section 7(A) loans), and tax exemptions for nonprofit organizations).
- —Other Federal support of child care programs includes support for child welfare services under title IV-B of the Social Security Act and support for services through the Community Development Block Grant Program under the Housing and Community Development Act.

Federal assistance for early childhood development services

- —The Head Start Program, authorized through fiscal year 1994, under authority of the Augustus F. Hawkins Human Services Reauthorization Act of 1990, provides Federal matching funds to Head Start agencies for services that help improve the social and learning skills and the nutrition and health status of low-income children before they start school. The fiscal year 1991 appropriation for Head Start was $1.9 billion, to serve an estimated 603,835 children.
- —The Child Care Food Program, authorized under section 17 of the National School Lunch Act, provides funds and commodities to States for meals served to children in public and private nonprofit day care centers, family group and day care homes, and Head Start centers. Estimated appropriations for the Child and Adult Care Food Program fiscal year 1990 equaled $813.1 million.[28] In fiscal year 1989, 1.4 million children participated daily during the peak month of participation.
- —In addition, three programs were authorized under the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 for fiscal years 1989 through 1993. These include a program to provide grants for up to 30 comprehensive child development centers, an Even Start Program to provide grants for the joint education of

---

[28] $7.332 million was for the adult care portion of the program.

young disadvantaged children and their parents, and a program to provide grants to Native Hawaiian organizations to operate a minimum of 11 family-based education centers in Hawaii.

Other programs

—Two Federal programs work to provide day care for specified groups of chlidren. One, the Dependent Care Planning and Development Program, authorized under the Human Services Reauthorization Act of 1986, authorizes 75 percent matching grants to States for dependent care services before and after school and for establishing or expanding local resource and referral systems (fiscal year 1988 appropriations equaled $8.4 million). Temporary Child Care for Handicapped Children and Crisis Nursuries (authorized under title II of the Children's Justice Act), authorizes 75 percent Federal matching grants to States to provide temporary care for handicapped children and children with chronic illnesses, and crisis nurseries and referrals for abused and neglected children (fiscal year 1988 appropriations equaled $4.8 million).

—The Federal Government also operates several programs which seek to train day care workers, support employers, and assist providers (Child Development Associate (CDA) scholarships, tax deductions for child care as a business expense, guaranteed loans for small businesses (section 7(A) loans), and tax exemptions for nonprofit organizations).

INCOME SOURCES OF FAMILIES WITH CHILDREN [29]

FEMALE-HEADED FAMILIES WITH CHILDREN

The economic well-being of children is reflected in the average level and distribution of income among families with children. Tables 58 through 61 present data on the income sources which families with children relied upon for economic support in 1989. Tables 58 and 59 describe sources for female-headed families with no husband present; tables 60 and 61 describe the sources of income upon which male-present families rely.

Table 58 shows that the percent of female-headed families receiving income from earnings (wages, salaries, self-employment and farm income), alimony or child support, as well as interest and dividends tends to increase as total income increases above the poverty threshold. In turn, families below the poverty threshold are more likely to receive public cash assistance, presumably AFDC, and food stamps—a form of near-cash assistance.

Half (49.0 percent) of all poor female-headed families with children had income from earnings. As table 59 shows, on average earnings accounted for about 28 cents of every dollar of income received. Seventy-five percent of poor female-headed families between 75 and 100 percent of poverty had income from earnings; for these families, earnings accounted for 48 percent of total income (see tables 58 and 59). In contrast, 96 percent of nonpoor female-headed families had earnings which on average accounted for 80 percent of total income.

---

[29] Please see Appendix H for similar income source data related specifically to the elderly. See Appendix I for data on trends in income and income inequality for families with children and other families.

TABLE 58.—PERCENT OF FEMALE-HEADED FAMILIES WITH CHILDREN WITH INCOME FROM VARIOUS SOURCES, BY RATIO OF TOTAL INCOME TO POVERTY THRESHOLD,[1] 1989

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Number of families (in thousands)	1,694	1,004	736	617	575	900	1,150	1,189	3,434	4,431	7,865
Earnings[2]	34.7	54.4	74.8	89.6	94.7	96.1	98.2	98.6	49.0	96.2	75.6
OASDI, railroad retirement	6.4	14.4	15.9	15.7	15.7	15.6	16.2	17.4	10.8	16.3	13.9
Pensions	0.8	1.8	3.4	3.1	5.1	3.5	6.3	9.0	1.7	5.8	4.0
Unemployment compensation, workers compensation, veterans payments	2.3	5.0	10.0	12.7	13.3	11.1	10.5	10.5	4.7	11.3	8.4
AFDC, SSI, general assistance	62.6	68.5	46.9	27.5	16.9	13.3	5.4	3.1	60.9	11.0	32.8
Child support, alimony	21.5	31.3	33.3	38.7	43.9	40.4	49.7	49.8	26.9	45.5	37.4
Interest, dividends[2]	8.6	12.1	16.1	24.4	33.9	47.2	58.5	78.1	11.2	53.5	35.0
Food stamps	71.1	69.1	52.5	33.1	22.6	8.9	3.1	0.9	66.5	10.4	34.9
Housing assistance	32.6	26.6	28.1	17.3	10.4	6.5	2.8	0.6	29.9	6.0	16.4
Family characteristics:											
Percent never-married	41.8	38.6	25.3	22.4	22.7	20.6	15.6	12.2	37.3	17.6	26.2
Percent with head age 15 to 19	4.3	2.4	0.7	0.8	0.8	0.3	0.2	0.0	2.9	0.3	1.5
Percent with head age 20 to 29	42.7	33.6	29.7	29.0	20.9	22.8	14.0	8.6	37.3	17.3	26.0
Percent with head 30 and over	53.0	64.1	69.6	70.2	78.3	77.0	85.7	91.4	59.8	82.3	72.5
Percent white non-Hispanic[3]	38.1	44.4	50.3	54.1	56.9	63.0	65.4	72.4	42.6	64.1	54.7
Percent black non-Hispanic	46.0	39.6	36.2	33.2	33.0	28.6	27.0	21.9	42.0	27.6	33.9
Percent Hispanic	15.8	16.0	13.5	12.8	10.1	8.5	7.7	5.8	15.4	8.4	11.4

[1] Based on census ("Orshansky") poverty levels. [2] Negative incomes (i.e. losses) set to zero. [3] Includes "other races."

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 59.—PERCENT OF TOTAL FAMILY INCOME FROM VARIOUS SOURCES, BY RATIO OF TOTAL INCOME TO POVERTY THRESHOLD FOR FEMALE-HEADED FAMILIES WITH CHILDREN, 1989 [1]

	Ratio of total income to poverty threshold										
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	Poor	Nonpoor	Total
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Earnings [2]	12.5	25.7	47.8	64.2	74.5	78.3	81.4	81.0	27.8	79.1	69.7
OASDI, railroad retirement	3.4	6.5	8.2	8.2	5.9	6.3	5.1	3.0	5.9	4.6	4.8
Pensions	0.3	0.4	1.2	0.9	0.8	0.7	1.5	1.9	0.6	1.5	1.3
Unemployment compensation, workers compensation, veterans payments	0.6	1.0	1.4	2.6	1.7	1.0	1.4	0.8	1.0	1.2	1.1
AFDC, SSI, general assistance	35.5	39.2	22.9	8.8	3.9	2.7	0.7	0.2	32.9	1.5	7.3
Child support, alimony	4.6	6.2	6.7	9.9	10.2	8.9	8.1	7.2	5.8	8.1	7.7
Interest, dividends [2]	0.4	0.3	0.3	0.8	0.8	1.3	1.6	5.9	0.3	3.4	2.9
Food stamps [3]	28.0	13.4	6.6	2.9	1.5	0.5	0.2	0.0	16.5	0.4	3.4
Housing assistance [3]	14.7	7.3	4.8	1.6	0.6	0.3	0.1	0.0	9.2	0.2	1.9
Mean income per family member [4]	$1,576	$2,581	$3,191	$3,904	$4,794	$6,001	$8,674	$15,422	$2,214	$8,696	$5,712
Mean family size	3.4	3.4	3.4	3.2	3.1	3.1	2.9	2.9	3.4	3.0	3.2
Percent with 50 percent or more of family income from public assistance [4]	66.4	54.9	29.6	8.5	1.7	1.0	0.0	0.0	55.2	1.6	25.0
Percent with 90 percent or more of family income from public assistance [4]	48.9	35.3	13.9	1.9	0.7	0.2	0.0	0.0	37.4	0.4	16.6

[1] Based on census ("Orshansky") poverty levels. [2] Negative incomes (i.e. losses) set to zero. [3] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income. [4] Includes cash values of food stamps and housing assistance. Income not adjusted for losses.

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

It is interesting to note that nonpoor female-headed families were almost twice as likely as poor female-headed families to receive child support or alimony—46 percent compared to 27 percent. For both poor and nonpoor female-headed families, child support on average accounted for roughly the same percentage share of total income.

Public assistance, mostly AFDC, was the most common source of cash income received by poor female-headed families with children. Approximately 61 percent of these families received cash public assistance which, on average, accounted for about 33 cents of every dollar received.

Food stamps, although not cash income, were an important source of income to poor female-headed families.[30] Nearly 67 percent received food stamps at some time during the year. For each dollar of income received, food stamps, on average, accounted for 17 cents.

MALE-PRESENT FAMILIES WITH CHILDREN

Among poor, male-present families (mostly married couple families) with children, earnings were on average the most common source and the largest component of total income (see tables 60 and 61). Some 84 percent of all such families had income from earnings, which accounted for 67 cents of every dollar received. Sixteen percent of poor male-present families received income from either unemployment compensation, workers' compensation, or veterans' payments, and these sources accounted for 4 cents of every dollar received. Twenty-five percent of poor families headed by a male received cash public assistance, which, on average, accounted for 11 cents of each dollar these families received.

Poor male-present families were much less likely than female-headed families to receive food stamps. Only 42 percent of poor male-present families received food stamps, compared with 67 percent of female-headed families (see tables 58 and 59).

---

[30] The cash value of food stamps was not included as part of total income for purposes of determining poverty status, but was included as part of total income for calculating the percentage share of total income.

TABLE 60.—PERCENT OF MALE-PRESENT FAMILIES WITH CHILDREN WITH INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] 1989

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Number of families (in thousands)	612	619	910	1,027	1,114	2,575	5,745	14,299	2,142	24,761	26,903
Earnings [2]	68.6	89.0	90.3	93.9	96.8	97.9	99.5	99.8	83.7	99.1	97.9
OASDI, railroad retirement	5.9	7.5	11.4	11.1	10.8	8.4	5.5	4.4	8.7	5.6	5.9
Pensions	0.5	1.1	2.9	3.5	3.4	4.3	3.7	5.3	1.7	4.7	4.4
Unemployment compensation, workers compensation, veterans payments	8.9	17.8	18.8	15.1	16.2	16.8	14.1	11.4	15.7	12.9	13.2
AFDC, SSI, general assistance	28.3	24.5	23.1	13.2	10.4	5.6	2.3	1.0	25.0	2.7	4.5
Child support, alimony	12.2	10.7	12.7	11.7	15.5	15.1	15.6	15.4	12.0	15.3	15.0
Interest, dividends [2]	20.6	19.3	21.1	31.5	36.3	46.9	66.4	86.6	20.4	73.3	69.1
Food stamps	46.0	50.7	33.8	19.7	12.7	6.4	1.4	0.2	42.2	2.5	5.6
Housing assistance	13.0	9.1	9.1	3.2	3.4	2.6	0.6	0.1	10.2	0.8	1.5
Family characteristics:											
Percent with head age 15 to 19	2.1	1.2	0.8	1.4	0.4	0.4	0.1	0.1	1.3	0.2	0.3
Percent with head age 20 to 29	27.0	28.7	25.3	30.4	24.4	23.8	19.3	10.0	26.7	15.1	16.0
Percent with head age 30 and over	71.0	70.1	73.9	68.2	75.2	75.8	80.7	90.0	72.0	84.8	83.8
Percent white non-Hispanic [3]	61.2	59.3	58.2	63.6	66.7	74.9	82.5	88.8	59.4	83.9	81.9
Percent black non-Hispanic	18.7	14.3	17.8	13.7	14.3	12.0	8.5	6.4	17.0	8.1	8.8
Percent Hispanic	20.1	26.4	24.0	22.7	19.0	13.2	9.0	4.8	23.6	8.0	9.2

[1] Based on census ("Orshansky") poverty levels.

[2] Negative incomes (i.e. losses) set to zero.

[3] Includes "other" races.

Note: Details may not sum to totals due to roundings.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 61.—PERCENT OF TOTAL FAMILY INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] FOR MALE-PRESENT FAMILIES WITH CHILDREN: 1989

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Earnings [2]	44.5	64.7	74.5	83.9	86.3	89.7	94.0	92.9	66.8	92.7	92.2
OASDI, railroad retirement	3.5	4.8	6.1	5.4	4.1	2.9	1.2	0.5	5.3	0.9	1.0
Pensions	0.2	0.5	0.7	0.9	0.8	1.1	0.7	0.9	0.6	0.9	0.9
Unemployment compensation, workers compensation, veterans payments	3.7	4.5	3.0	2.2	2.4	2.1	1.2	0.6	3.5	0.9	0.9
AFDC, SSI, general assistance	16.3	11.7	8.7	3.1	2.5	0.9	0.3	0.1	10.8	0.2	0.4
Child support, alimony	3.6	2.0	1.8	1.5	1.9	1.6	1.1	0.8	2.2	0.9	0.9
Interest, dividends [2]	3.4	1.1	0.8	1.3	1.2	1.4	1.5	4.2	1.3	3.5	3.5
Food stamps [3]	19.6	8.8	3.5	1.4	0.7	0.2	0.0	0.0	7.7	0.1	0.2
Housing assistance [3]	5.4	1.8	0.8	0.2	0.2	0.1	0.0	0.0	1.8	0.0	0.1
Mean income per family member [4]	$1,164	$2,099	$2,765	$3,478	$4,201	$5,404	$7,687	$15,927	$2,138	$11,650	$10,799
Mean family size	4.4	4.6	4.8	4.5	4.5	4.3	4.2	3.9	4.6	4.1	4.1

---

[1] Based on census ("Orshansky") poverty levels.

[2] Negative incomes (i.e. losses) set to zero.

[3] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

[4] Includes cash values of food stamps and housing assistance. Incomes not adjusted for losses.

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TRENDS IN DEMOGRAPHIC CHARACTERISTICS AND INCOME COMPOSITION OF FAMILIES WITH CHILDREN

Female-headed families with children

Table 62 shows how the demographic characteristics of female-headed families and the composition of their incomes have changed between 1979 and 1989. The number of female-headed families who are poor has increased from 2.46 million in 1979 to 3.43 million in 1989, accounting for almost 1.0 million of the 1.7 million increase in the total number of female-headed families since 1979. The percent of all such households in which the head has never been married has increased for both poor and nonpoor families. In 1979, 26 percent of females heading poor families were never-married; by 1989, this had jumped to 37 percent. For all families, the percentage of never-married heads increased from 17 to 26. The percentage of female-headed Hispanic families has also increased for both poor and nonpoor families, with a total increase from 8 to 11 percent.

The change in the composition of nonpoor family income is evident in that only 11 percent of nonpoor families are receiving AFDC, SSI, or general assistance as part of their income in 1989, whereas 18 percent were receiving such benefits in 1979. Child support and alimony are received by 27 percent of poor female-headed families in 1989, as compared to 19 percent in 1979. For poor families, both the percentage of families receiving food stamps and the percent of total income that food stamps represent has remained relatively constant, from 1979 to 1989. However, the percentage of nonpoor families receiving food stamps has decreased substantially, from 17 percent in 1979 to 10 percent in 1989. A larger percentage of poor families are receiving housing assistance—30 percent in 1989 compared with 22 percent in 1979—but there is only a slight increase, from 8.0 percent to 9.2 percent in the percentage of total income housing assistance represents for these families. For the entire population of female-headed families, governmental benefits represented 24 percent of total income in 1979, and 18 percent of total income in 1989.

Male-present families with children

Table 63 shows the similar data for families in which there is a male present. As with female-headed families, the percentage of poor male-present Hispanic families has grown substantially from 16 percent in 1979 to 24 percent in 1989. The percentage of poor male-present families receiving pensions from OASDI or railroad retirement has decreased from 14 in 1979 to 9 in 1989. As a percent of total income, OASDI and railroad retirement decreased from 8 to 5 percent over this same time period.

TABLE 62.—TRENDS IN DEMOGRAPHIC CHARACTERISTICS AND INCOME COMPOSITION OF FEMALE-HEADED FAMILIES WITH CHILDREN, 1979 and 1989

	Poor [1]		Nonpoor [1]		Total	
	1979	1989	1979	1989	1979	1989
Number of families (in thousands)	2,458	3,434	3,729	4,431	6,187	7,865
Family Characteristics:						
Percent never-married	26.0	37.3	10.2	17.6	16.5	26.2
Percent with head age 15 to 19	3.9	2.9	0.4	0.3	1.8	1.5
Percent with head age 20 to 29	36.4	37.3	21.7	17.3	27.6	26.0
Percent with head 30 and over	59.6	59.8	77.8	82.3	70.6	72.5
Percent white non-Hispanic [2]	43.1	42.6	69.4	64.1	59.0	54.7
Percent black non-Hispanic	44.9	42.0	24.7	27.6	32.7	33.9
Percent Hispanic	12.0	15.4	5.9	8.4	8.3	11.4
Average family size	3.7	3.4	3.2	3.0	3.4	3.2
Percent with income from:						
Earnings [3]	49.7	49.0	94.8	96.2	76.9	75.6
OASDI, railroad retirement	12.6	10.8	21.5	16.3	18.0	13.9
Pensions	1.1	1.7	4.4	5.8	3.0	4.0
UC and other compensation	6.3	4.7	14.9	11.3	11.5	8.4
AFDC, SSI, general assistance	65.0	60.9	18.2	11.0	36.8	32.8
Child support, alimony	18.6	26.9	44.0	45.5	33.9	37.4
Interest, dividends [3]	13.4	11.2	53.6	53.5	37.6	35.0
Food stamps	67.2	66.5	16.6	10.4	36.7	34.9
Housing assistance	21.6	29.9	6.0	6.0	12.2	16.4
Percent of total income from:						
Earnings [3]	24.8	27.8	74.2	79.1	64.9	69.7
OASDI, railroad retirement	5.7	5.9	6.8	4.6	6.6	4.8
Pensions	0.4	0.6	1.2	1.5	1.1	1.3
UC and other compensation	1.5	1.0	1.5	1.2	1.5	1.1
AFDC, SSI, general assistance	38.1	32.9	3.8	1.5	10.2	7.3
Child support, alimony	4.8	5.8	8.1	8.1	7.5	7.7
Interest, dividends [3]	0.3	0.3	2.9	3.4	2.4	2.9
Food stamps [4]	16.5	16.5	0.9	0.4	3.8	3.4
Housing assistance [4]	8.0	9.2	0.7	0.2	2.1	1.9
Mean income per family member [5] (1989 dollars)	$2,308	$2,214	$7,642	$8,696	$5,345	$5,712
Percent with 50 percent or more of income from public assistance [5]	58.8	55.2	4.5	1.6	26.1	25.0
Percent with 90 percent or more of income from public assistance [5]	39.0	37.4	1.3	0.4	16.3	16.6

[1] Based on census ("Orshansky") poverty levels.

[2] Includes "other races."

[3] Negative incomes (i.e. losses) set to zero.

[4] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

[5] Includes cash values of food stamps and housing assistance and includes negative incomes (i.e. losses). 1979 income converted to 1989 dollars using the CPI-X1 price index.

Note: Details may not sum to totals due to rounding.

Source: March 1980, 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 63.—TRENDS IN DEMOGRAPHIC CHARACTERISTICS AND INCOME COMPOSITION OF MALE-PRESENT FAMILIES WITH CHILDREN, 1979 and 1989

	Poor [1]		Nonpoor [1]		Total	
	1979	1989	1979	1989	1979	1989
Number of families (in thousands)	1,663	2,142	24,315	24,761	25,978	26,903
Family Characteristics:						
Percent with head age 15 to 19	1.1	1.3	0.3	0.2	0.4	0.3
Percent with head age 20 to 29	25.4	26.7	19.3	15.1	19.6	16.0
Percent with head 30 and over	73.6	72.0	80.4	84.8	80.0	83.8
Percent white non-Hispanic [2]	66.2	59.4	86.1	83.9	84.8	81.9
Percent black non-Hispanic	18.0	17.0	7.7	8.1	8.3	8.8
Percent Hispanic	15.8	23.6	6.2	8.0	6.8	9.2
Average family size	4.8	4.6	4.2	4.1	4.3	4.1
Percent with income from:						
Earnings [3]	82.3	83.7	99.4	99.1	98.3	97.9
OASDI, railroad retirement	14.3	8.7	5.9	5.6	6.4	5.9
Pensions	2.1	1.7	4.1	4.7	4.0	4.4
UC and other compensation	16.8	15.7	17.2	12.9	17.2	13.2
AFDC, SSI, general assistance	24.3	25.0	3.2	2.7	4.5	4.5
Child support, alimony	7.4	12.0	11.3	15.3	11.0	15.0
Interest, dividends [3]	27.4	20.4	73.9	73.3	71.0	69.1
Food stamps	41.8	42.2	3.5	2.5	6.0	5.6
Housing assistance	7.3	10.2	1.1	0.8	1.5	1.5
Percent of total income from:						
Earnings [3]	62.5	66.8	93.2	92.7	92.7	92.2
OASDI, railroad retirement	8.1	5.3	1.0	0.9	1.1	1.0
Pensions	0.7	0.6	0.9	0.9	0.9	0.9
UC and other compensation	4.3	3.5	1.0	0.9	1.1	0.9
AFDC, SSI, general assistance	10.3	10.8	0.3	0.2	0.4	0.4
Child support, alimony	1.5	2.2	0.7	0.9	0.7	0.9
Interest, dividends [3]	1.7	1.3	2.8	3.5	2.8	3.5
Food stamps [4]	8.7	7.7	0.1	0.1	0.2	0.2
Housing assistance [4]	2.3	1.8	0.1	0.0	0.1	0.1
Mean income per family member [5] (1989 dollars)	$1,975	$2,138	$10,289	$11,650	$9,689	$10,799
Percent with 50 percent or more of income from public assistance [5]	15.3	16.5	0.2	0.2	1.2	1.5
Percent with 90 percent or more of income from public assistance [5]	7.1	8.9	0.0	0.1	0.5	0.8

---

[1] Based on census ("Orshansky") poverty levels.

[2] Includes "other races."

[3] Negative incomes (i.e. losses) set to zero.

[4] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

[5] Includes cash values of food stamps and housing assistance, and includes negative incomes (i.e. losses). 1979 income converted to 1989 dollars using the CPI-X1 price index.

Note: Details may not sum to totals due to rounding.

Source: March 1980, 1990 Current Population Surveys (CPS). Table prepared by CRS.

CHILD POVERTY STATISTICS

Table 64 describes the number of U.S. children below poverty, the percentage composition, and the poverty rates, by race for selected years. For children under 18 in 1989, the poverty rates were 43.7 for black children, 14.8 for white children and 36.2 for Hispanic children. Compared with white children, the poverty rate was three times higher for blacks and two and one-half times higher for Hispanics.

Table 65 and 66 represent the child poverty population and poverty rates by family type and race from 1966 to 1989. The overall poverty rate for children in female-headed families reached its lowest level since 1980 of 51.1. Children in male-present families, however, faced a slight increase from the 1988 levels, from 10.0 to 10.4.

Table 67 depicts the number of poor children and their poverty rates by age, from 1966 to 1989. Between 1966 and 1979, the poverty rates of children under 6 remained relatively stable. The rate began to increase in 1980, peaking in 1983 at 25.0. For children 6 to 17 years of age, the poverty rate began to grow rather noticeably at about the same time. In 1989, the poverty rate of children under 6 was 22.5, nearly one child in every four. The poverty rate of children 6 to 17 years of age was 18.1, nearly one child in every five. The difference in the poverty rates of the two age groups has grown over time, from less than 1 percentage point in 1966 to 4 percentage points in 1989.

Table 68 shows the number and percent of children in poverty and the poverty rates by the number of children in the family for 1989. The poverty rate significantly increases as the size of the family becomes larger.

TABLE 64.—NUMBERS, PERCENT COMPOSITION, AND RATES OF CHILDREN BELOW POVERTY [1], BY RACE

[Numbers in thousands]

	Total	Black	White	Hispanic [2]
1974	10,156	3,755	6,223	NA
1975	11,104	3,925	6,927	NA
1976	10,273	3,787	6,189	1,443
1977	10,288	3,888	6,097	1,422
1978	9,931	3,830	5,831	1,384
1979	10,377	3,833	6,193	1,535
1980	11,543	3,961	7,181	1,749
1981	12,505	4,237	7,785	1,925
1982	13,647	4,472	8,678	2,181
1983	13,911	4,398	8,862	2,312
1984	13,420	4,413	8,472	2,376
1985	13,010	4,157	8,253	2,606
1986	12,876	4,148	8,209	2,507
1987	12,963	4,441	7,842	2,690
1988[3]	12,455	4,296	7,435	2,631
1989	12,590	4,375	7,599	2,603

TABLE 64.—NUMBERS, PERCENT COMPOSITION, AND RATES OF CHILDREN BELOW POVERTY [1], BY RACE—Continued

[Numbers in thousands]

	Total	Black	White	Hispanic [2]
Percentage Composition				
1974		37.0	61.3	NA
1976		36.9	60.2	14.0
1980		34.3	62.2	15.2
1981		33.9	62.3	15.4
1982		32.8	63.6	16.0
1983		31.6	63.7	16.6
1984		32.9	63.1	17.7
1985		32.0	63.4	20.0
1986		32.2	63.8	19.5
1987		34.3	60.5	20.8
1988 [3]		34.5	59.7	21.1
1989		34.7	60.4	20.7
Rates				
1974	15.4	39.8	11.2	NA
1975	17.1	41.7	12.7	NA
1976	16.0	40.6	11.6	30.2
1977	16.2	41.8	11.6	28.3
1978	15.9	41.5	11.3	27.6
1979	16.4	41.2	11.8	28.0
1980	18.3	42.3	13.9	33.2
1981	20.0	45.2	15.2	35.8
1982	21.9	47.6	17.0	39.4
1983	22.3	46.7	17.5	38.1
1984	21.5	46.5	16.7	39.2
1985	20.7	43.6	16.2	40.3
1986	20.5	43.1	16.1	37.7
1987	20.5	45.6	15.4	39.6
1988 [3]	19.5	43.5	14.5	37.6
1989	19.6	43.7	14.8	36.2

---

[1] Includes all persons under 18 below the poverty level, including unrelated children.

[2] Hispanic origin may be of any race; this category is not exclusive.

[3] The 1988 numbers have been revised since the last publication of the Green Book.

NA=Not available.

Source: "Money Income and Poverty Status of Families and Persons in the United States," 1989 (table 20).

TABLE 65.—COMPOSITION OF CHILD POVERTY POPULATION BY FAMILY TYPE AND RACE: 1966–1989

[In thousands]

Year	Total poor	Female head				Percent of total	Male present				Percent of total
		Nonwhite	White	Hispanic [1]	Total		Nonwhite	White	Hispanic [1]	Total	
1966..	12,146	2,150	2,112	NA	4,262	35.1	2,792	5,092	NA	7,884	64.9
1967..	11,427	2,316	1,930	NA	4,246	37.2	2,382	4,799	NA	7,181	62.8
1968..	10,739	2,334	2,075	NA	4,409	41.1	2,032	4,298	NA	6,330	58.9
1969..	9,500	2,179	2,068	NA	4,247	44.7	1,655	3,598	NA	5,253	55.3
1970..	10,235	2,442	2,247	NA	4,689	45.8	1,651	3,891	NA	5,546	54.2
1971..	10,344	2,398	2,452	NA	4,850	46.9	1,605	3,889	NA	5,494	53.1
1972..	10,082	2,821	2,273	NA	5,094	50.5	1,477	3,511	NA	4,988	49.5
1973..	9,453	2,710	2,461	606	5,171	54.7	1,281	3,001	758	4,282	45.3
1974..	9,966	2,678	2,683	621	5,361	53.8	1,209	3,396	793	4,605	46.2
1975..	10,881	2,784	2,813	694	5,597	51.4	1,350	3,394	925	5,284	48.6
1976..	10,080	2,870	2,713	636	5,583	55.4	1,176	3,321	789	4,497	44.6
1977..	10,029	2,965	2,693	686	5,658	56.4	1,121	3,250	716	4,371	43.6
1978..	9,722	3,060	2,627	663	5,687	58.5	988	3,047	692	4,035	41.5
1979..	9,993	3,006	2,629	668	5,635	56.4	1,079	3,279	837	4,358	43.6
1980..	11,114	3,053	2,813	809	5,866	52.8	1,244	4,004	909	5,248	47.2
1981..	12,069	3,185	3,120	909	6,305	52.2	1,455	4,309	966	5,764	47.8
1982..	13,139	3,447	3,249	990	6,696	51.0	1,411	5,032	1,127	6,443	49.0
1983..	13,427	3,359	3,388	1,018	6,747	50.2	1,534	5,146	1,233	6,680	49.8
1984..	12,929	3,395	3,377	1,093	6,772	52.4	1,448	4,709	1,223	6,157	47.6
1985..	12,483	3,344	3,372	1,247	6,716	53.8	1,300	4,467	1,266	5,767	46.2
1986..	12,257	3,421	3,522	1,194	6,943	56.6	1,121	4,192	1,219	5,313	43.3
1987..	12,435	3,600	3,474	1,241	7,074	56.9	1,285	4,076	1,390	5,361	43.1
1987 [2]	12,275	3,586	3,433	1,250	7,019	57.2	1,291	3,966	1,356	5,257	42.8
1988..	11,935	3,530	3,424	1,294	6,954	58.3	1,310	3,671	1,282	4,981	41.7
1989..	12,001	3,553	3,255	1,158	6,808	56.7	1,285	3,908	1,338	5,193	43.3

[1] Persons of Hispanic origin may be of any race.

[2] Revised.

NA: Not available.

Note: Includes only related children in families. 1987 revised through 1989 estimates are not comparable to prior years due to processing changes in the CPS.

Source: U.S. Department of Commerce. Bureau of the Census. "Characteristics of Low Income Population: 1983" P–60 No. 147; 1983 rev-1987 from U.S. Department of Commerce. Bureau of the Census. "Money Income and Poverty Status in the United States: 1987" P–60 No. 161; 1987 rev to 1989 figures from March Current Population Survey (CPS).

TABLE 66.—POVERTY RATE OF CHILDREN BY FAMILY TYPE AND RACE

Year	Total	Female head				Male present			
		Black	White	Hispanic	Total	Black	White	Hispanic	Total
1966	17.4	76.6	46.9	NA	58.2	39.9	9.2	NA	12.6
1967	16.3	72.4	42.1	NA	54.3	35.3	8.7	NA	11.5
1968	15.3	70.5	44.4	NA	55.2	29.8	7.8	NA	10.2
1969	13.8	68.2	45.2	NA	54.4	25.0	6.7	NA	8.6
1970	14.9	67.7	43.1	NA	53.0	26.0	7.3	NA	9.2
1971	15.1	66.6	44.6	NA	53.1	25.5	7.4	NA	9.3
1972	14.9	69.5	41.1	NA	53.1	24.1	6.8	NA	8.6
1973	14.2	67.2	42.1	68.7	52.1	21.7	6.0	18.8	7.6
1974	15.1	65.0	42.9	64.3	51.5	20.0	6.9	20.0	8.7
1975	16.8	66.0	44.2	68.4	52.7	22.1	8.2	23.8	9.8
1976	15.8	65.6	42.7	67.3	52.0	19.4	7.1	20.8	8.5
1977	16.0	65.7	40.3	68.6	50.3	19.9	7.1	17.9	8.5
1978	15.7	66.4	39.9	68.9	50.6	17.6	6.8	17.2	7.9
1979	16.0	63.1	38.6	62.2	48.6	18.7	7.3	19.2	8.5
1980	17.9	64.8	41.6	65.0	50.8	20.3	9.0	22.9	10.4
1981	19.5	67.7	42.8	67.3	52.3	23.4	10.0	24.5	11.6
1982	21.3	70.7	46.5	71.8	56.0	24.1	11.6	27.8	13.0
1983	21.8	68.3	47.1	70.6	55.4	23.7	12.0	27.2	13.5
1984	21.0	66.2	45.9	71.0	54.0	24.3	11.0	27.5	12.5
1985	20.1	66.9	45.2	72.4	53.6	18.8	10.4	27.4	11.7
1986	19.8	67.1	46.3	66.7	54.4	17.0	9.8	25.8	10.8
1987	20.0	68.3	45.8	70.1	54.7	19.8	9.5	28.3	10.9
1987r	19.7	66.9	45.0	69.8	53.7	19.1	9.3	27.7	10.6
1988	19.0	64.7	44.9	69.6	52.9	18.7	8.5	25.4	10.0
1989	19.0	63.1	42.5	64.3	51.1	20.3	9.1	25.5	10.4

Note: Persons of Hispanic origin may be of any race.
NA denotes not available.

Sources: U.S. Department of Commerce. Bureau of the Census. "Money Income and Poverty Status in the United States" P-60 No. 147 and 161; 1987r–1989 data from March Current Population Survey (CPS). Table prepared by CRS.

TABLE 67.—NUMBER OF CHILDREN POOR UNDER 6 AND FROM 6 TO 17 YEARS AND THEIR POVERTY RATES

Year	Total number of children under 18	Total number under 6	Total number of poor children under 6	Poverty rate of children under 6	Total number of poor children 6–17 years	Poverty rate of children 6–17 years
1966	70,218	23,779	4,304	18.1	8,085	17.4
1967	70,408	23,171	4,055	17.5	7,601	16.1
1968	70,385	22,249	3,659	16.6	7,295	15.2
1969	69,090	21,681	3,361	15.5	6,330	13.4
1970	69,159	21,556	3,601	16.7	6,839	14.4
1971	68,816	20,898	3,579	17.1	6,972	14.5
1972	67,930	20,510	3,388	16.5	6,896	14.5
1973	66,959	20,043	3,204	16.0	6,438	13.7
1974	66,134	19,887	3,361	16.9	6,795	14.7
1975	65,079	19,353	3,522	18.2	7,582	16.6
1976	64,028	18,971	3,358	17.7	6,915	15.3
1977	63,137	18,518	3,426	18.5	6,862	15.4
1978	62,311	18,789	3,344	17.8	6,587	15.1
1979	63,375	19,012	3,479	18.3	6,898	15.5
1980	62,914	19,974	4,054	20.3	7,489	17.4
1981	62,449	20,396	4,487	22.0	8,018	19.1
1982	62,345	20,789	4,899	23.6	8,748	21.1
1983	62,334	21,039	5,302	25.0	8,609	20.8
1984	62,447	21,196	5,066	23.9	8,354	20.3
1985	62,876	21,526	4,951	23.0	8,059	19.5
1986	62,948	21,656	4,796	22.1	8,080	19.6
1987	63,290	21,860	4,984	22.8	7,979	19.3
1988 (revised)	63,747	22,232	4,957	22.3	7,499	18.1
1989	64,144	22,505	5,071	22.5	7,518	18.1

Source: "Money Income and Poverty Status in the United States: 1989," Current Population Reports, U.S. Department of Commerce. Data on children under 6 from "Five Million Children: A Statistical Profile of Our Poorest Young Citizens," National Center for Children in Poverty, 1990.

TABLE 68.—NUMBER OF CHILDREN IN POVERTY AND POVERTY RATES BY NUMBER OF CHILDREN IN THE FAMILY, 1989

Number of children in family	Number of children (in 1,000s)	Percent of children	Number of poor children (in 1,000s)	Percent of poor children	Poverty rate
1	14,108	22.3	1,589	13.2	11.3
2	24,942	39.4	3,377	28.1	13.5
3	14,712	23.3	3,245	27.0	22.1
4	5,664	9.0	1,850	15.4	32.7
5 or more	3,800	6.0	1,940	16.2	51.1
Total	63,226	100.0	12,001	100.0	19.0

Source: March 1990 Current Population Survey.

Table prepared by CRS.

Distribution of child population in poverty areas [31] [32]

Table 69 describes percentages of poor children by ethnic group, residing in poverty areas. Minority children, especially low-income children, are concentrated in major metropolitan locales. In 1988, 19 percent of all children and 47 percent of those in poor families lived in poverty areas. Whereas 71 percent of poor black children and 58 percent of poor Hispanic children lived in poverty areas, only a third of poor white children resided there. Between the years 1976 and 1988, the proportion of Hispanic children living in central cities rose from 47 to 54 percent, with the proportion in poverty areas growing from 34 to 41 percent. During these same years, the proportion of black children residing in central cities remained approximately the same (that is, around 56 percent), with the proportion in poverty areas being nearly constant (about 53 percent). Only 25 percent of white children represented central city dwellers in 1988 and only 12 percent lived in poverty areas. The figures for 1976 are 21.5 percent and 12.7 percent, respectively.

---

[31] This section borrows heavily from "U.S. Children and their Families: Current Conditions and Recent Trends, 1989," a report of the Select Committee on Children, Youth, and Families, September, 1989.

[32] Poverty areas are defined as those where 20 percent or more of the population was identified as being below the poverty level according to the last census.

TABLE 69.—DISTRIBUTION OF CHILD POPULATION IN CENTRAL CITIES, SUBURBS, AND NON-METROPOLITAN AREAS, AND IN POVERTY AREAS, 1976 AND 1988

	Percent distribution	
	1976	1988
All related children under 18	100.0	100.0
Living in metro areas	66.5	76.6
Inside central cities	26.9	30.4
Outside central cities	39.6	46.1
Living outside metro areas	33.5	23.4
Living in poverty areas	20.9	18.9
Poor children in areas	[1] 46.1	[1] 46.8
White children	100.0	100.0
Living in metro areas	65.0	75.3
Inside central cities	21.5	25.0
Outside central cities	43.5	50.3
Living outside metro areas	35.0	24.7
Living in poverty areas	12.7	12.3
Poor children in areas	[1] 32.7	[1] 32.6
Black children	100.0	100.0
Living in metro areas	73.9	81.5
Inside central cities	56.9	56.3
Outside central cities	17.0	25.2
Living outside metro areas	26.1	18.5
Living in poverty areas	54.0	52.7
Poor children in areas	[1] 70.7	[1] 71.1
Hispanic children	100.0	100.0
Living in metro areas	80.8	91.6
Inside central cities	46.8	53.9
Outside central cities	34.0	37.8
Living outside metro areas	19.2	8.4
Living in poverty areas	33.9	40.6
Poor children in areas	[1] 51.3	[1] 57.5

[1] Percentage of poor children in ethnic group who live in poverty areas.

Note: Shifts in metro residence are partly due to changes in definition of metropolitan statistical areas. The changes in definition have increased the area and population of metropolitan areas. Determination of poverty status is based on family income in previous year (i.e., 1975 and 1987).

Source: Child Trends, calculated from U.S. Bureau of the Census, Current Population Reports, Series P–60, No. 106, Tables 9 and 42, and No. 163, Tables 4 and 12, and unpublished data.

THE DYNAMICS OF CHILDHOOD POVERTY

Tables 70 through 72 examine childhood poverty by tracking children and their families through time. Why is a "dynamic" perspective important? Imagine two surveys of the population taken 5 years apart. The observed incidences of poverty might be the same as they were in 1970 and 1975, for example, at about 12 percent of the population. A static comparison would suggest that not much has changed, a conclusion which may or may not be warranted. The 12 percent of the population reported to be poor in 1975 could be exactly the same group of individuals who were noted to be poor in 1970, or they could be an entirely new group. The implications are important. The former inference evidences the existence of a group of long-term poor, or underclass. The latter provides a picture of transitory poverty, probably associated with individual life cycle changes or cyclical economic change. Only by following a representative group of individuals over time is it possible to distinguish among the different processes underlying a static picture of poverty.

The Survey Research Center at the University of Michigan has collected information on 5,000 American families since 1968. Data from the Panel Survey of Income Dynamics, reported here, are drawn from a study of "Children in Poverty" (1985), prepared for the use of the Committee on Ways and Means by the Congressional Research Service (CRS) and the Congressional Budget Office (CBO).[33] As of 1985, the Panel Study of Income Dynamics (PSID) comprised the only reliable source of income and demographic information for a representative sample of American families over a significant period of time. Some of the findings were based on then, as yet unpublished research. As the (1985) CRS and CBO report noted, the work was used by permission of the authors, but may be subject to some revision.

Before interpreting the PSID figures, several caveats are in order. It is risky to draw inferences from a single source of data. Potential problems of sample bias or error are difficult to evaluate without independent replication of results from other samples. Unfortunately, other comparable sources of data do not exist. The PSID has been subjected to careful scrutiny and still retains its credibility. Nevertheless, the reader should consider the findings to be tentative.

Duration of poverty [34] [35]

Table 70 presents information on the incidence of short-term and persistent poverty for the total population as well as for children.

---

[33] The information presented below draws heavily on the PSID research. The primary sources of information for this section were: Bane, Mary Jo. Household Composition and Poverty, IRP Conference Paper presented in Williamsburg, VA. December 6–8, 1984. University of Wisconsin-Madison. Duncan, Greg J., et al. Years of Poverty, Years of Plenty: The Changing Fortunes of American Workers and Families. Ann Arbor, Institute for Social Research, University of Michigan, 1984. Duncan, Greg J. and Rogers, Willard. A demographic analysis of Childhood Poverty, unpublished paper, Ann Arbor, MI: Survey Research Center, University of Michigan, 1984. Elwood, David T. and Bane, Mary Jo, Slipping Into and Out of Poverty: The Dynamics of Spells. NBER: Working Paper #1199. Harvard University. 1983. Hill, Martha S. and Ponza, M. Poverty and Welfare Dependence Across Generations. Economic Outlook USA. Summer, 1983, vol. 10, No. 3. Lillia, Mark. Why the "Income Distribution" is so Misleading. The Public Interest, #73: National Affairs Inc. New York, N.Y. Fall 1984.

[34] Estimates of poverty rates from the PSID data are consistently lower than official Census Bureau estimates. Those responsible for the PSID at the Survey Research Center of the University of Michigan believe the difference results from more complete accounting for income on the PSID than the Current Population Survey. The Census Bureau acknowledges that the CPS does underestimate income. It is not known exactly how much more accurate PSID income information is. For the types of analysis presented here, it is more important that the data collection be consistent over time, than accurate at a point-in-time.

[35] The number of years used to classify an individual as experiencing short term versus persistent poverty is somewhat arbitrary. One could certainly argue that someone poor for 6 out of 10 years is persistently poor. However, even if persistent poverty were defined as 5 or more years out of 10, it would not change the finding that most people who experience poverty do so for a short time.

The data for children and the total population are not directly comparable. For all persons, the time period is a 10-year span (1969–78), while for children, it is the 15-year period of "childhood" for children between the ages of 1 and 3 in 1968.

TABLE 70.—INCIDENCE OF SHORT-TERM AND PERSISTENT POVERTY

	Percent of all persons in category (10-year period)	Percent of children in category (15-year period)
Poor from 1 to 10 years	24.4	29.1
Short term (from 1 to 4 years)	19.0	22.1
Poor from 5 to 10 years	5.4	7.0
Persistent poor (from 8 to 10 years for total population, from 10 to 15 years for children)	2.6	4.8

Source: Duncan et al. Years of Poverty Years of Plenty. Duncan and Rogers. Demographic Analysis of Childhood Poverty.

Although the incidence of poverty for children cannot be directly compared to that of the total population due to differences in the measurement period, it is still possible to note that the patterns for children and the overall population are similar. One quarter of all persons and 29.1 percent of all children were poor at some time. This proportion is particularly interesting since the PSID poverty rate for 1975 was only 8.9 percent compared to the official estimate of 12.3 percent. The official proportion of the population that would have been poor at some point during this time period as measured by the Current Population Survey is not known.

The table also shows that a much smaller proportion of the population experiences mid- to long-run (i.e., persistent) poverty. As classified by the researchers, 2.6 percent of all individuals and 4.8 percent of all children lived in persistently poor families.

Duration of poverty, race and region

The relatively small proportion of persistently poor children masks the fact that almost 30 percent of all black children were persistently poor (note table 71). In the PSID sample, almost 90 percent of the children who were poor for 10 or more years of their childhood were black. Conversely, white children make up about three quarters of the short-term (1 to 4 years) poor children. (Even though the rate for white short-term poverty is lower than that for black children—19.8 versus 32.3, that rate is applied to a much higher base—over 86 percent of all children were white). Nevertheless, the probability of poverty of any duration is much higher for blacks than for whites.

A child's likelihood of facing long-term poverty increased if the child was from the South, in a one-parent family, or living in a rural area. According to Duncan and Rogers (1984), "the geographic distribution of persistent poverty becomes somewhat more balanced when cash welfare payments are subtracted from total family incomes, owing to the fact that welfare payments tend to be more generous in large cities and northern areas."

TABLE 71.—INCIDENCE OF SHORT-TERM AND PERSISTENT POVERTY OF CHILDREN BY RACE

	White	Black
Poor from 1 to 4 years out of 15 years	19.8	32.3
Poor from 5 to 9 years out of 15 years	4.6	17.7
Poor from 10 to 14 years out of 15 years	0.6	24.0
Poor all 15 years of childhood	0.0	4.9

Source: Duncan and Rogers. Demographic Analysis of Childhood Poverty.

Poverty throughout childhood

Duncan and Rogers (1984) provide a final way of looking at the dynamics of childhood poverty. They calculate the expected number of years that children with different demographic characteristics can expect to spend in poverty during their first 15 years of life. Table 72 summarizes their estimates.

TABLE 72.—EXPECTED YEARS OF CHILDHOOD POVERTY OUT OF FIRST 15 YEARS OF LIFE

	Nonblack	Black
All households	0.8	5.4
Characteristics of household at birth of child:		
Never married mother	6.2	6.0
Teenage mother	1.2	5.4
Education of head:		
8 years	1.2	5.6
12 years	0.7	5.3
Characteristics of household throughout childhood (15 years):		
Head disabled	3.3	10.9
Lived in South	0.8	6.4
Lived out of South	0.7	4.3
Large city	0.7	3.9
Rural area	1.1	8.1
1 parent	3.2	7.3
2 parent	.5	3.0

Source. Duncan and Rogers. Demographic Analysis of Childhood Poverty.

Black dominance of long-run poverty is reinforced in table 72. On average, black children spent over one-third (5.4 years) of their childhood (first 15 years) poor. White children spent only 5 percent (0.8 years) of their childhood poor.

Household characteristics affect the expected number of years in poverty. Using table 72, compare the expected years in poverty for all nonblack and black households to those of households with various characteristics. The greater the difference between the expected years for a particular characteristic and the overall rate, the stronger seems the association between the characteristic and poverty. In general, family characteristics have a greater influence on the poverty of white children than black children. For example, being born to a white, never-married female increases the expected number of years of child poverty by almost 700 percent (from 0.8 years to 6.2 years), while the corresponding increase for black children is just over 10 percent (from 5.4 years to 6.0 years). The only family characteristics that have a similar impact on black and nonblack children are disability of the household head and living in an one-parent family (both for the full 15 years of childhood).

It is interesting that geographic location has a significant influence for blacks but not for nonblacks. For nonblack children, living in the South or non-South or in a large city or rural area has little impact on the expected years of poverty. Black children residing in rural areas and/or in the South can expect more years in poverty than their counterparts in large cities and/or in the non-South.

Additional studies on the dynamics of childhood poverty conducted by David Ellwood reinforce those results found by Duncan et al.[36] Using the PSID, a cohort of children were examined who were born between 1967 and 1973 and were followed for a 10-year period.

Table 73 shows the poverty experiences of children born in an average year. Of the 3,500,000 children born around 1970, 2,278,000 (65.1 percent) avoided poverty entirely during their first 10 years of life; 686,000 (19.6 percent) temporarily lived in poverty (poverty lasting 1-3 years); 269,000 (7.7 percent) were poor for roughly half of these first 10 years; and 267,000 (7.6 percent) were poor for virtually their entire first 10 years of childhood. Therefore, while almost two-thirds of all children born in this period escaped poverty altogether, over 1 million of the children born each year spent some part of their childhood growing up poor.

Although the number of children considered to be long-term poor (7-10 years in poverty) is relatively small (7.6 percent), this group endures almost 50 percent of the poverty years experienced by children. The third column of table 73 shows the percentage of all poverty that a person in each of the groups must confront. In other words, it shows the portion of children observed to be poor in a single year that can be expected to be part of the short-term, medium-term, or long-term poor. As the table indicates, the large number of temporarily poor children suffer only a quarter of all childhood poverty, the medium-term poor account for another quarter, and, as previously noted, the long-term poor account for one-half of the poverty of children.

The odds for a white or black child to face poverty are remarkably different as shown in table 74. The overwhelming majority of white children will escape poverty (73 percent) while only a small minority of black children will (22 percent). Over one-half of all black children will spend at least 4 to 10 of their first 10 years of life in poverty. Only 3 percent of white children compared to over one-third of all black children will be considered long-term poor. Overall, even though blacks and other minorities represent just 18 percent of the children in this sample, they represent 65 percent of the children who are considered long-term poor.

---

[36] *Ellwood, David T. (1989), "Poverty through the eyes of children," unpublished manuscript,* Harvard University, Cambridge, MA.

Table 75 shows the chance a child will face some spell of poverty, given the living arrangement of the child's family. Growing up in a two-parent home does not guarantee that a child will avoid poverty. Some 20 percent of all children in two-parent families experience poverty, although for most children it is only temporary. In contrast, children who spend time in a single-parent family are very likely to face at least some poverty, with only one-third of these children avoiding poverty altogether. Children raised entirely in single-parent families are at a very high risk of facing poverty. As many as 61 percent of all children in this group will be poor throughout most of the early years of their childhood, while only 7 percent will escape poverty altogether.

TABLE 73.—NUMBER AND PERCENT DISTRIBUTION OF CHILDREN BORN AROUND 1970 AND THE PERCENT DISTRIBUTION OF CHILDHOOD POVERTY, BY NUMBER OF YEARS POOR IN THE FIRST 10 YEARS OF LIFE

	Never poor	Short-term poor (1–3 years)	Medium-term poor (4–6 years)	Long-term poor (7–10 years)
Number of children (in thousands)	2,278	686	269	267
Percentage of children	65.1	19.6	7.7	7.6
Percentage of all childhood poverty	0	23.6	27.8	48.6

Note: Based on data from the Panel Study of Income Dynamics.

Source: Ellwood, D.T. (1989). "Poverty through the eyes of children." Unpublished manuscript, Harvard University, Cambridge, MA.

TABLE 74.—EXTENT OF POVERTY DURING THE FIRST 10 YEARS OF CHILDHOOD BY RACE FOR CHILDREN BORN AROUND 1970

[Numbers in thousands]

	Never poor	Percent	Short-term poor (1–3 years)	Percent	Medium-term poor (4–6 years)	Percent	Long-term poor (7–10 years)	Percent
White	2,089	73	539	19	150	5	91	3
Black	107	22	104	22	103	22	163	34
Other	82	53	43	28	16	10	13	8
Total	2,278	65.1	686	19.6	269	7.7	267	7.6

Note: Based on data from the Panel Study of Income Dynamics.

Source: Ellwood, D.T. (1989). "Poverty through the eyes of children." Unpublished manuscript, Harvard University, Cambridge, MA.

TABLE 75.—EXTENT OF POVERTY DURING THE FIRST 10 YEARS OF CHILDHOOD BY FAMILY TYPE FOR CHILDREN BORN AROUND 1970

[Numbers in thousands]

	Never poor	Percent	Short-term poor (1–3 years)	Percent	Medium-term poor (4–6 years)	Percent	Long-term poor (7–10 years)	Percent
Always in a two-parent family	2,005	80.0	340	13.6	110	4.4	50	2.0
Some years in a two-parent family	259	32.8	321	40.7	116	14.7	92	11.7
Always in a single-parent family	14	6.7	25	11.9	43	20.8	125	60.6
Total	2,278	65.1	686	19.6	269	7.7	267	7.6

Note: Based on data from the Panel Study of Income Dynamics.

Source: Ellwood, D.T. (1989). "Poverty through the eyes of children." Unpublished manuscript, Harvard University, Cambridge, MA.

Transitions into and out of poverty

What types of events are associated with the beginnings or ends of periods of poverty? Are changes in family structure more directly related to spells of poverty than changes in the earnings of family heads? What events have the most severe consequences when they occur, and what positive or negative events happen most frequently? Do different factors help explain black and white poverty? Some preliminary answers to these questions have been advanced from research on the Panel Study of Income Dynamics.

Birth into poverty.—A significant portion of childhood years of poverty or spells of poverty begin with birth. Estimates are that from a fifth to a quarter of poor children are born into poverty. Being born into poverty can result from a number of factors. A family that was near poor before the birth of a child may become poor after the birth if the family's income does not increase enough to offset the increased economic resources needed by the child. Alternatively, the birth of a child could result in decreased hours of work, and therefore earnings, of adults in the family. This decrease in earnings could be enough to drop the family below the poverty level. One estimate is that for children born into poor female-headed families, one-third of poverty was a result of the birth. Finally, a child may be born into a family that was poor before the birth.

Events after birth.—Although significant, birth into poverty did not account for 75 to 80 percent of children's transitions into poverty. Later events must have caused these poverty beginnings.[37] In general, events after birth did not play as important a role in the poverty of black children as white children. Duncan and Rogers (1984) attribute 85 percent of white childhood poverty, but only 55 percent of black childhood poverty, to events subsequent to birth. Events such as divorce, however, did have a significant impact on black families. In fact, the likelihood of a child becoming poor as a result of a number of events was higher for blacks than whites. Because, in general, white families with children are farther above the poverty line than black families, the occurrence of a negative event (e.g., unemployment) is less likely to make them poor. Even so, postbirth events explained more of white childhood poverty than black: (*a*) because there is less white poverty (as a percent of all white families) to explain and (*b*) a much higher proportion of black children were born into poverty.

---

[37] However, events that happen after the birth of a child may have their origins before or after the birth.

Tables 76 and 77 both look at the relationships between childhood poverty and events. Both tables illustrate the need to consider not only how severe the consequences of an event are if it occurs, but also how frequently the event occurs overall. For example, table 76 shows that becoming a female-headed family explained 41 percent of the poverty spells of children in female-headed families. The beginning of a female-headed family explains only 14.9 percent of all childhood poverty spells, however, because the event happens less frequently than other negative events (e.g., decline in earnings of male-headed family).

Summing all the changes in earnings events accounts for over 50 percent of all childhood spells of poverty and nearly two-thirds of the poverty spells of children in male-headed families (see table 76). The picture is quite different for female-headed families, where changes in earnings account for just one-quarter of the spells of poverty.

TABLE 76.—PRIMARY REASONS FOR BEGINNINGS OF SPELLS OF CHILDHOOD POVERTY (BY FAMILY TYPE)

[In percent]

Primary reason for beginning of spell	Children with poverty experiences		
	All children	Male-headed families	Female-headed families
Changes in earnings:			
Earnings of head fell	38.5	51.1	13.4
Earnings of wife fell	7.0	10.5	
Earnings of other family member fell	7.1	3.6	14.2
Total for earnings changes	52.6	65.2	27.6
Need level/poverty rose	6.7	7.7	4.8
Unearned income fell	5.7	5.1	6.9
Beginning of female-head family	14.9	1.6	41.2
Born into poverty	20.0	20.2	19.5
Total	100.0	100.0	100.0
Percents of all beginnings	100.0	66.5	33.5

Source: Derived from Bane, Mary Jo, Household Composition and Poverty.

An interesting insight from table 76 (and reinforced in table 77) is that for female-headed families, declines in the earnings of other family members are as influential as a decline in earnings of the female-head of the family. Presumably, the work of older children is important to economic resources of low-income female-headed families. This hypothesis is supported by another statistic from the PSID. A child leaving home decreased the poverty rate for male-headed families, because the departing child decreased the family's needs by more than the value of his income. The poverty status of female-headed families, on the other hand, was worsened by a child leaving. In this case, the older child's income exceeded the additional economic need he brought the family.

Table 77 also estimates the impact of events on childhood poverty transitions on all children. The first column of the table estimates the combined effect on all children of the probability that an event occurs (column 5) and the effect of the event given that it occurs (column 2). For example, the first entry in column 1 (0.53 percent) shows that one-half of 1 percent of all children moved into or out of poverty, while experiencing a transition from a two-parent family, or vice versa. Changes in hours worked dominate poverty transitions (also in table 54). Changes in hours worked by other family members (excluding the head of family and spouse) had the most impact on poverty transitions (1.68 percent) followed by changes in hours worked by the male head of family (0.92 percent).

The impact of events on those children experiencing them is shown in column 2. Here, those events usually thought to be influential for the economic well-being of children stand out: transitions from two- to one-parent families, employment status and hours worked by female heads of household, and disability of a male head of household. These events happen too infrequently, however, to be the prime explanatory events for childhood poverty.[38]

Finally, columns 3 and 4 compare the effects of the favorable and unfavorable occurrence of an event on transitions into and out of poverty. In most cases, the effects are symmetrical. The families of children climbing out of poverty experience the favorable side of an event with about the same frequency as the families of children falling into poverty experienced the unfavorable side of the event. The one exception is the hours worked by other family members. Here, almost one-third of all children climbing out of poverty lived in families where the hours worked by other family members increased by at least 500 hours. While decreases in the hours worked by other family members were experienced by a higher proportion of those falling into poverty than any other event (19 percent), the unfavorable event was not nearly so influential as the favorable event.

---

[38] This table does not, however, control for the duration of a period of poverty. Information presented previously indicates that events such as transitions to female-headed families results in longer periods of poverty than labor supply changes.

TABLE 77.—SUMMARY OF EFFECTS OF VARIOUS EVENTS ON TRANSITIONS INTO AND OUT OF POVERTY

[In percent]

Events	All children: net change in overall poverty rate associated with event	Children experiencing event: net change in poverty rate of children experiencing event	Children falling into poverty: fraction experiencing the negative event	Children climbing out of poverty: fraction experiencing the positive event	All children: fraction of all children who experience the event
I. Major changes in family structure:					
A. Transition from two-to-one-parent or vice versa	0.53	13.6	9	8	4.1
II. Major changes in labor supply of family members:					
A. Unemployment of household head changes by one month or more:					
1. Male head	.92	8.1	15	16	11.4
2. Female head	.03	1.6	3	3	2.2
B. Work hours of head changes by 500 hours or more for reasons other than unemployment:					
1. Male head	.47	2.1	16	12	21.6
2. Female head	.47	13.0	7	9	3.7
C. Work hours of wife changes by 500 hours or more	.56	2.5	7	13	21.2
D. Work hours of other family members changes by 500 hours or more	1.68	7.0	19	32	23.9
III. Changes in disability status of heads of intact families:					
Male head	.19	10.4	4	2	2.0
Female head	.05	6.3	2	1	0.8

Note: Table reads (first table cell), 0.53 percent of all children moved into or out of poverty as a result of a transition from a 2-parent to a 1-parent family or vice versa. A more detailed version of the table that separates the transitions into poverty from transitions out of poverty can be found in: Duncan and Rogers. The Prevalence of Childhood Poverty. Survey Research Center, University of Michigan, Ann Arbor, 1985.

Source: Duncan and Rogers. Demographic Analysis of Childhood Poverty.

As shown by table 78, a parent's educational attainment bears a relationship to the annual earnings that are available for a child's support. For mother-child families, the 1982–83 poverty rate of children whose mothers had some college work was 45 percent lower for whites (30 percent lower for blacks) than for children whose mothers ceased their education after completion of high school. By contrast, the poverty rate of children whose fathers undertook college study was 52 percent lower for whites (61 percent lower for blacks) than for children whose fathers did not attend college.

At each level of a parent's schooling, poverty rates of black children exceeded those of whites: all married-couple families by 85 percent; single-female-headed families by 51 percent. For female-headed families, the relative racial discrepancy widened with the level of educational attainment. With female-headed families whose mothers completed some college, nearly one of every two children was poor, with the child poverty rate (47.3) more than double that of corresponding white children (22.7). For children of single mothers who failed to complete high school, black poverty rates were only 13 percent above those of whites.

TABLE 78.—POVERTY RATES AMONG CHILDREN IN MARRIED-COUPLE AND SINGLE FEMALE-HEADED FAMILIES BY RACE AND PARENT'S HIGHEST GRADE OF EDUCATION COMPLETED: 1982–83

	Total	White	Black
Married-couple families (total)	12.4	11.3	20.9
Father's education only:			
Failed to complete high school [1]	31.1	29.0	39.6
Completed high school	7.8	7.3	13.1
High school diploma only	11.0	10.1	17.5
Completed some college [2]	5.0	4.8	6.9
Father and mother's education:			
Neither completed high school [1]	39.1	36.8	44.9
Only mother completed high school	20.4	18.6	32.8
Only father completed high school	20.2	18.6	29.7
Both completed high school	6.6	6.2	11.1
Single female-headed families (total)	55.8	47.4	71.5
Mother's education:			
Failed to complete high school [1]	80.6	76.8	86.8
Completed high school	43.1	34.4	61.6
High school diploma only	50.3	41.0	67.6
Completed some college [2]	29.5	22.7	47.3

[1] Includes persons who did not start high school.

[2] Includes persons who were graduated from college.

Note.—Table prepared by CRS using data from the combined March 1984 and March 1983 Current Population Survey. Data are for "own related children" in primary and secondary families only. Poverty rates in this table were calculated on the basis of the Census Bureau definition, applied to two years' data.

HOMELESSNESS IN AMERICA [39]

From the early 1980s on, the general public has become increasingly aware that many people in this country are unable to house themselves. Since then, numerous reports have sought to describe the homeless—who they are, their number, and the expanding variety of services evolving to help them. Estimates of the number of homeless adults and children vary according to the definition of homelessness utilized, as well as by the types of places enumerators visit to secure a count (see, for example, table 79). A recent report by the Urban Institute integrates the findings of three separate studies,[40] with additional analyses. Drawing on a nationally representative sample of interviews with homeless users of services and service providers in large cities, it provides new data on the number of homeless, their characteristics, how they fare, and the type and extent of services available to them.

The Urban Institute report estimates that there are 229,000 "service-using" (using shelters or soup kitchens) homeless in cities of over 100,000 people. This is based upon a sample of 20 cities, in which 400 service providers were randomly selected. From the number of 229,000, the 560,000–680,000 range of the total homeless population was derived using a number of assumptions. The total U.S. population was broken down into people in cities of over 100,000 (25.4 percent), people in other parts of Metropolitan Statistical Areas (51.2 percent), and people outside MSAs (23.4 percent). It was assumed that in cities of over 100,000 people, the service-using homeless constitute two-thirds of the homeless population. It was further assumed that the rate of homelessness in the second category was equal to one-third the rate of homelessness in the first category, in the third category the rate of homelessness was closer to one-sixth the rate in the first category. Further alternative assumptions produced the final range of estimates between 560,000 and 680,000.

The general makeup of America's homeless population is hard to determine, as the diversity of homeless people and their circumstances is great. Although the stereotypical male, middle-aged, alcoholic homeless person is still evident as part of the homeless population, the fact that many families are homeless makes it difficult to classify the entire homeless population. In a sampling of service users, researchers found that 77 percent of the homeless are single, leaving 23 percent as members of homeless families—8 percent are adults in families and 15 percent are children. This last number is increasing greatly; children represent the fastest-growing subpopulation of the homeless population. Furthermore, 88 percent of the heads of homeless families are female. The increase in cases of single motherhood combined with a dearth of affordable housing has contributed to the growth of the family component of the homeless population.

---

[39] All data in this subsection are from "Report to Congress on the Prepared Meals Provisions," by the Urban Institute, 1988.

[40] The three studies were as follows: the first, a national study of homeless people by the U.S. Department of Agriculture's Food and Nutrition Service; the second, an examination of state funding and activities related to homelessness in six states, by the Interagency Council on the Homeless (Department of Housing and Urban Development); and, the third, a project reviewing available studies estimating the size of the homeless population and describing its characteristics, made possible by the U.S. Department of Agriculture, as part of its work with the Interagency Council on the Homeless.

TABLE 79.—ESTIMATES OF THE NUMBER OF HOMELESS CHILDREN

Year and source	Number	Explanatory notes
1987—Urban Institute	35,000 homeless children	Includes only homeless using shelters over a 7-day period in cities with pop. over 100,000. Based on a nationally representative sample of service-using homeless individuals and providers of food and shelter for the homeless. Data collected in March 1987.
1988—U.S. Department of Housing and Urban Development.	40,000 homeless children[1]	Includes only shelter-using population in cities with population over 25,000 on an average night in 1988. Based on a probability sample of 200 shelters.
1987—National Academy of Sciences.	100,000 homeless children[2].	Refers to any given night in the U.S. Estimate based on total of 735,000 homeless on any given night. Of these, 25 percent are members of intact families, of whom 55 percent are children.
1988—U.S. Department of Education.	220,000 school-aged homeless children[3].	Based on State-collected data received from 45 States. Combines data of a variety of types, including daily counts, annual estimates, and partial counts from two states. The majority of states (40) reported annual counts. Fourteen States included data on numbers of preschool children, which totalled 33,119.
1984—National Coalition of Homeless.	500,000 Homeless children	Refers to any given night in U.S. Calculated by advocacy groups based on their contacts with service providers and shelter operators nationwide.

---

[1] HUD reported that the total number of homeless people was 180,000, 30 percent of whom were single-parents and their children, and 6 percent of whom were couples with children.

[2] The sources for the numbers used in this estimate are as follows: 735,000 homeless on any given night—National Alliance to End Homelessness., 1987; 25% are family members—U.S. Conference of Mayors, 1986; of these 55% are children—Barbanel, J., 1985.

[a] State Educational Agencies encountered difficulties in gathering the data, and used different methods and sources. Thus, the quantity and quality of information varied across locations.

Note: Estimates of the homeless population take two forms: annual estimates and point-in-time counts. The former attempts to assess the number of people in need of help in a year, the latter provides information on the number of shelter beds that are needed on a given night.

Source: "U.S. Children and Their Families: Current Conditons and Recent Trends, 1989," a report of the Select Committee on Children, Youth, and Families, September 1989.

As shown in table 80, there are significant differences in the makeup of the homeless family subpopulation and the homeless individual subpopulation. The majority of the adult homeless population is male (81 percent); however, whereas 88 percent of all homeless individuals are male, only 12 percent of homeless adults in families are male. Overall, 54 percent of the adult homeless population is nonwhite; however, whereas 51 percent of homeless individuals are nonwhite, more than three-quarters (78 percent) of homeless adults in families are nonwhite. Of all homeless adults, 51 percent are between 31 and 50 years old. The elderly are the most notably underrepresented age category, as compared to their percentage of the general population. The average homeless individual has been homeless for a median of 12 months, the average homeless family 4.5 months. The median income for an individual is $64 a month; for a family it is $300 per month. Both of these numbers fall below 50 percent of the poverty level in 1987. Homeless men are more likely to have earned income; homeless women are more likely to collect means-tested benefits.

In addition to children, minorities also represent a growing portion of the homeless. There are disproportionate percentages of blacks and Hispanics among the homeless in comparison to the overall population. Furthermore, homeless families are even more likely to be black or Hispanic than homeless individuals. Education is also a determining factor; a large percentage (48 percent) of the homeless did not graduate from high school. Veterans constitute a significant portion of the homeless; it is estimated that one-third of all homeless men are Vietnam veterans. Twenty-two percent of all homeless are employed.

The homeless suffer from a variety of economic and noneconomic problems. Basic health problems such as the common cold are exacerbated by the fact that homeless people, even those in shelters, must return to the streets during the day, unable to rest and recover. More serious though are the problems of mental illness associated with the homeless. Twenty percent of homeless people interviewed admitted to a history of mental hospitalization, and 49 percent expressed and showed signs of severe depression, indicating a need for treatment. The policies of deinstitutionalization of mental patients account for a number of mentally ill homeless persons.

Concerning nutrition, 37 percent of homeless persons report eating one meal a day or less and 36 percent report going at least 1 day a week without any nourishment. Even many homeless who eat regularly, two to three times a day, rate their diet as nutritionally only fair or poor. On average, the homeless eat foods from 2.7 of the five major food groups daily. Homeless families report having a more nutritionally balanced diet than homeless individuals.

Assistance to the homeless is provided in the forms of services and benefits. Services are available in the form of soup kitchens and shelters. Nearly all (95 percent) soup kitchens and shelters offer meals and/or beds to the homeless at no cost. However, the shelters were originally established to provide emergency relief for short periods of time; the length of stays is getting increasingly longer, and the shelters increasingly crowded. Families are more likely to use shelters, while single men tend to use soup kitchens. Homeless who do not use any services tend to have more mental and health problems and less steady income, whether in earnings or benefits. They have been homeless longer, and have substantially poorer eating habits than the service-using population.

The services offered to the homeless receive very little Government funding; only 26 percent of providers receive any form of Government support. For the most part, they are able to operate on donations from USDA commodities, the United Way, churches, and businesses. The Government supplies financial support to the homeless in a variety of benefits: AFDC, food stamps, general assistance, etc. Families, especially those headed by a female, are much more likely to receive the benefits available. Approximately 50 percent of homeless families get food stamps, in comparison to only 15 percent of homeless individuals.

The increasing number of homeless families probably indicates that the economic status of the poor is declining. For the most part, families appear to be homeless for primarily financial reasons. Homeless individuals, on the other hand, are more likely to need assistance in dealing with problems relating to mental illness, malnutrition, psychological distress, personal health care, and substance abuse.

TABLE 80.—CHARACTERISTICS OF HOMELESS ADULTS IN CITIES OF POPULATION OVER 100,000

[In weighted percentages]

—	Homeless adults		Total
	Single	In families	
Total	77	8	[1] 85
Sex:			
Male	88	12	81
Female	12	88	19
Race:			
Black	39	54	41
Hispanic	9	20	10
White	49	22	46
Other	3	4	3
Age:			
18 to 30	NA	NA	30
31 to 50	NA	NA	51
51 to 65	NA	NA	16
66+	NA	NA	3

TABLE 80.—CHARACTERISTICS OF HOMELESS ADULTS IN CITIES OF POPULATION OVER 100,000—Continued

[In weighted percentages]

	Homeless adults		Total
	Single	In families	
Marital status:			
Married	9	23	10
Divorced/separated	30	25	29
Widowed	6	6	5
Never married	56	47	55
Medical history:			
Mental hospitalization	20	11	19
Chemical dependency	35	12	33
Criminal history:			
Jailed for 5 or more days	56	18	52
State or Federal prison	26	2	24
Number of months homeless:			
Mean	41.3	14.6	NA
Median	12.0	4.5	NA
Monthly cash income:			
Mean	$146	$301	NA
Median	$64	$300	NA
Receiving benefits:			
Food Stamps	15	50	NA
AFDC	1	33	NA
General assistance	10	33	NA
Eating habits:			
Percent who eat less than once a day	8	1	7
Once a day	31	19	30
Twice a day	38	39	38
Three or more times a day	25	41	25
No food over a 2-day period, once a week	18	5	17

[1] The remaining 15 percent of homeless individuals are children in homeless families.

NA: Not available.

Source: All data from a study done by the Urban Institute on 1,704 service-using homeless persons.

The following facts about the homeless appear in the Urban Institute study, "America's Homeless" (1989):

1. *Family structure.*—Adults make up 194,000 of the service-using homeless; children accompanying them make up the remaining 35,000. Ten percent of homeless households are families with children.

2. *Gender.*—Most of the homeless (81 percent) are male.

3. *Race.*—Fifty-four percent are nonewhite. Homeless people are three to four times as likely to be black and slightly more likely to be Hispanic than the general population.

4. *Education.*—Forty-eight percent have not graduated from high school (compared with 19 percent for all U.S. adults).

5. *Length of homelessness.*—Homeless persons tend to be homeless for substantial periods (median of 10 months for the entire sample). One-fifth have been homeless three months or less, while a like proportion have been homeless four years or more. Households with children are likely to be homeless for shorter periods (41 percent for three months or less).

6. *Income.*—The average monthly income per person was $135, less than one-third of the Federal poverty level. Men were more likely to report income from handouts; women from means-tested government benefits such as food stamps, Aid to Families with Dependent Children (AFDC), and General Assistance (GA).

7. *Work history.*—The homeless have been jobless longer than they have been homeless. About half had not had a steady job (three months with the same employer) in more than two years.

8. *Health.*—Over half (56 percent) reported at least one health problem, including 15 percent with joint problems, 15 percent with high blood pressure, and 10 percent with problems walking. Physical health problems may have contributed to becoming homeless.

9. *Mental health.*—One-fifth reported a history of mental hospitalization and a similar proportion had attempted suicide. Half rated high enough on a scale of depression and demoralization to indicate the need for immediate treatment. Women with children with them reported a much lower rate of mental hospitalization, but still had five times the normal rate of suicide attempts.

10. *Institutionalization.*—One-third had been patients in a detoxification or alcohol/drug treatment center. Sixty percent of the single men, 22 percent of the single women, and 15 percent of the women with children had spent more than three or four days in a county jail (possibly some as a direct result of being homeless). In addition, 29 percent of single men, but just 2 percent of all women, had served time in a State or Federal prison.

COMBINED IMPACT OF AFDC, FOOD STAMPS, AND FEDERAL TAX POLICY UPON THE INCOME OF FEMALE-HEADED FAMILIES: 1960 TO 1990

This section examines the effect of AFDC, food stamps and Federal tax policy on the disposable income of female-headed families. The analysis calculates the weighted-average disposable income (weighted across States by 1980 State populations) available to female-headed families with either two or three children, at various wage levels. Disposable income includes wages, AFDC and food stamp benefits, and Federal taxes (income plus payroll). It does not include the value of health-care benefits. To make comparisons across time, wages are expressed as a percentage of the appropriate poverty threshold. Alaska and Hawaii are not included in this analysis, but the District of Columbia is included. Thus, the maximum number of States is 49. A complete description of the methodology is presented at the end of this section.

Table 81 presents the combined AFDC and food stamp benefit levels (in real 1990 dollars) for a female-headed family of four with no wages. This table covers the 31-year period from 1960 through 1990.

In real terms, weighted-average annual AFDC benefits by themselves declined 33 percent over the three decade period, from $8,446 to $5,704 (see last row of table). Since 1972, real AFDC benefits have declined 36 percent, from $8,875 to $5,704. Looking only at recent years, real AFDC benefits increased between 1984 and 1986, from $6,022 to $6,228, but since then have steadily declined to their 1990 levels.

Benefits from the food stamp program, which was created in the late 1960's, have on average offset some of the decline in AFDC benefits relative to inflation. Over the entire 31-year period, the weighted average benefit from AFDC and food stamps grew 2.8 percent in real terms, from $8,446 in 1960 to $8,684 in 1990. Since 1972, however, the average annual combined benefit for this family type has declined by 23 percent, from $11,199 to $8,684. Looking only at recent years, the combined AFDC and food stamp benefit increased between 1984 and 1986, from $8,751 to $8,967, but declined in 1988 to $8,684.

The benefit level in several States (Alabama, Arkansas, Delaware, Florida, Maine, Mississippi, South Carolina, and Tennessee) increased by over 50 percent in real terms from 1960 to 1990. In 20 States, total benefits (AFDC only in 1960, and food stamps plus AFDC in 1988) declined in real terms from 1960 to 1990. In 15 of these States (Idaho, Illinois, Kansas, Massachusetts, Montana, New Jersey, New Mexico, New York, North and South Dakota, Ohio, Oregon, Washington, Wisconsin and Wyoming), the decline was over 10 percent.

Table 82 shows the average disposable income of a mother and three children (without child care expenses) between 1972 and 1990, at wage levels between 0 and 125 percent of the poverty level. Also included in this table are projections for 1990 based on current law. As discussed below in the methodology section, these 1990 income projections take into account the tax changes enacted in the Omnibus Reconciliation Act of 1990.

This table illustrates that families with wages equal to 50 percent of the poverty level experienced a 24-percent decline in disposable income between 1972 and 1990. The decline for families earning 75 percent of the poverty level was 20 percent. The decline in disposable income is due, in part, to the loss of AFDC as an income supplement to wages. In 1972, all States paid AFDC benefits to a family with wages equal to 50 percent of the poverty threshold; by 1990, 26 States paid AFDC to such a family.

TABLE 81.—COMBINED AFDC AND FOOD STAMP BENEFIT LEVELS FOR A FAMILY OF FOUR WITH NO INCOME

[1990 constant dollars [1]]

	1960	1964	1968	1972	1976	1980	1984	1985	1986	1987	1988	1989	1990	Percent change	
														1960–90	1972–90
Alabama	2,914	3,403	4,011	7,534	7,885	6,642	6,045	5,996	5,939	5,785	5,794	5,654	5,736	96.8	−23.9
Arizona	7,100	6,780	6,039	9,800	9,089	7,923	7,493	7,440	8,108	7,886	7,853	7,645	7,659	7.9	−21.8
Arkansas	3,497	3,592	4,056	7,902	7,982	7,176	6,531	6,848	6,815	6,775	6,869	6,706	6,769	93.6	−14.3
California	11,392	10,878	9,960	12,338	12,594	12,177	11,492	11,689	11,924	11,752	11,890	11,815	11,615	2.0	−5.9
Colorado	8,637	7,166	8,338	11,341	10,606	9,350	8,953	8,850	8,779	8,534	8,586	8,344	8,323	−3.6	−26.6
Connecticut	11,657	11,637	13,836	13,861	13,096	11,030	11,238	11,342	11,463	11,250	11,324	11,213	11,347	−2.7	−18.1
Delaware	5,246	7,538	8,428	8,978	10,818	8,830	8,064	7,992	8,068	7,983	8,048	8,079	8,071	53.9	−10.1
District of Columbia	8,796	8,399	8,293	11,262	11,340	9,323	8,382	8,635	8,849	8,737	8,874	8,937	8,885	1.0	−21.1
Florida	4,133	3,946	3,831	8,768	8,561	7,736	7,398	7,461	7,557	7,490	7,584	7,512	7,600	83.9	−13.3
Georgia	5,776	5,515	5,634	8,899	8,136	7,242	7,102	7,257	7,597	7,471	7,537	7,370	7,399	28.1	−16.9
Idaho	11,074	10,174	10,726	12,391	11,919	9,563	8,149	8,074	8,017	7,799	7,769	7,680	7,693	−30.5	−37.9
Illinois	10,226	9,479	12,574	12,128	11,397	9,336	8,403	8,492	8,428	8,280	8,231	7,943	8,177	−20.0	−32.6
Indiana	5,829	5,565	6,760	10,369	10,104	8,870	7,853	7,788	7,737	7,819	7,788	7,583	7,600	30.4	−26.7
Iowa	9,167	9,627	10,997	11,367	12,150	10,257	8,942	8,840	9,009	8,756	8,827	8,734	8,852	−3.4	−22.1
Kansas	9,697	9,364	10,681	13,441	12,305	9,870	8,974	9,115	9,199	9,067	9,448	9,026	8,656	−10.7	−35.6
Kentucky	6,676	6,913	8,428	9,477	9,815	7,803	7,112	7,073	7,036	6,852	7,101	7,043	7,088	6.2	−25.2
Louisiana	5,723	5,464	5,228	7,823	8,329	7,509	6,985	6,950	6,916	6,736	6,748	6,591	6,659	16.4	−14.9
Maine	5,829	6,274	6,174	9,398	10,645	9,363	9,255	9,307	9,470	9,394	9,421	9,398	9,473	62.5	0.8
Maryland	8,001	8,474	8,022	10,238	9,950	9,016	8,714	8,896	9,025	8,936	9,065	8,764	8,822	10.3	−13.8
Massachusetts	11,604	11,191	12,980	14,149	12,710	10,257	9,408	9,718	10,141	10,225	10,405	10,080	9,969	−14.1	−29.5
Michigan (Wayne)	7,418	8,095	11,087	14,464	13,057	11,350	9,175	9,544	9,700	9,883	9,579	9,575	9,289	25.2	−35.8
Minnesota	10,703	10,234	11,988	13,887	12,710	11,150	10,973	10,851	10,742	10,477	10,340	10,018	9,910	−7.4	−28.6
Mississippi	2,649	2,530	2,479	6,450	6,231	6,269	5,637	5,602	5,896	5,744	5,754	5,616	5,700	115.2	−11.6
Missouri	5,829	5,565	5,589	8,400	8,561	8,536	7,768	7,829	7,847	7,664	7,639	7,468	7,567	29.8	−9.9
Montana	10,809	10,966	10,095	10,395	10,143	9,083	9,006	8,911	8,839	8,659	8,595	8,353	8,432	22.0	−18.9
Nebraska	6,888	6,577	9,014	10,921	10,954	9,603	8,953	8,850	8,779	8,534	8,614	8,371	8,348	21.2	−23.6

Nevada	5,617	6,071	7,121	9,608	10,085	8,856	7,387	8,043	7,987	7,770	8,196	7,972	7,970	41.9	−17.0
New Hampshire	9,432	9,259	11,448	12,706	11,957	9,897	9,048	9,074	9,089	9,703	9,700	9,504	9,423	−0.1	−25.8
New Jersey	12,240	12,436	14,963	13,493	12,150	10,190	9,196	9,309	9,230	9,311	9,221	8,849	8,802	−28.1	−34.8
New Mexico	9,855	9,396	8,248	9,677	9,246	8,229	7,821	7,757	7,707	7,538	7,519	7,326	7,827	−20.6	−19.1
New York (NYC)	12,028	12,934	12,529	13,204	13,424	11,017	10,673	10,641	10,837	10,519	10,771	10,190	10,494	−12.8	−20.5
North Carolina	7,047	7,703	6,490	9,162	9,139	7,469	6,848	7,308	7,266	7,210	7,278	7,096	7,189	2.0	−21.5
North Dakota	10,809	11,788	11,312	12,863	12,420	10,110	9,133	9,197	9,119	8,862	8,790	8,698	8,818	−18.4	−31.4
Ohio	9,750	7,210	8,698	10,238	10,182	9,030	8,138	8,237	8,318	8,237	8,190	8,040	8,168	−16.2	−20.2
Oklahoma	8,213	8,247	7,887	9,949	10,761	9,323	8,202	8,125	8,418	8,186	8,141	8,087	8,079	−1.6	−18.8
Oregon	10,385	9,372	10,186	11,997	13,636	10,550	9,767	9,861	9,911	9,810	9,700	9,214	9,274	−10.7	−22.7
Pennsylvania	7,842	8,267	9,600	13,204	12,478	9,750	8,900	9,095	9,240	8,978	9,124	8,858	9,011	14.9	−31.8
Rhode Island	8,690	8,477	11,988	11,892	12,208	9,857	9,251	9,413	9,692	10,355	10,128	10,015	9,908	14.0	−16.7
South Carolina	3,338	3,643	4,191	7,718	7,538	6,776	6,689	6,899	6,976	6,794	6,823	6,715	6,777	103.0	−12.2
South Dakota	9,750	9,127	10,321	12,469	11,706	9,483	8,435	8,349	8,659	8,418	8,363	8,247	8,297	−14.9	−33.5
Tennessee	4,239	5,059	5,408	8,453	7,827	6,642	6,287	6,460	6,465	6,349	6,535	6,503	6,693	57.9	−20.8
Texas	4,663	4,958	5,138	8,873	7,982	6,536	6,393	6,613	6,785	6,610	6,628	6,476	6,550	40.5	−26.2
Utah	8,955	8,904	8,338	11,157	11,706	10,390	9,006	9,044	8,969	8,717	8,651	8,521	8,491	−5.2	−23.9
Vermont	7,418	7,083	11,222	13,782	12,594	12,031	11,090	11,209	11,003	11,008	11,120	10,983	10,927	47.3	−20.7
Virginia	7,842	8,221	8,608	11,839	11,282	8,736	8,519	8,748	8,679	8,437	8,382	8,149	8,138	3.8	−31.3
Washington	12,611	10,609	12,078	12,706	12,710	11,817	10,621	10,460	10,602	10,293	10,164	9,655	9,662	−23.4	−24.0
West Virginia	5,829	6,191	7,256	8,820	10,085	7,989	7,144	7,747	7,697	7,490	7,472	7,282	7,315	25.5	−17.1
Wisconsin	11,975	11,421	10,771	12,916	13,462	11,724	11,238	11,056	11,073	10,815	10,303	9,982	9,877	−17.5	−23.5
Wyoming	10,332	10,119	9,104	10,947	10,490	9,203	8,636	8,543	8,478	8,244	8,196	7,972	7,970	−22.9	−27.2
Average	8,084	7,997	8,736	10,891	10,738	9,201	8,498	8,582	8,655	8,533	8,553	8,364	8,394	3.8	−22.9
Weighted average	8,446	8,317	8,966	11,199	10,928	9,426	8,751	8,862	8,967	8,828	8,862	8,648	8,684	2.8	−22.5
AFDC benefits (weighted average)	8,446	8,317	8,966	8,875	8,072	6,797	6,022	6,095	6,228	6,132	6,056	5,900	5,704	−32.5	35.7

---

[1] Converted to constant dollars using the CPI–U price index.

Note: For 1960, 1964, and 1968 this is only AFDC benefits. While some families may have received food stamps, the program was only operational in one-third of the counties. Only 2.2 million individuals participated in the food stamp program during fiscal year 1968.

Source: Committee on Ways and Means.

TABLE 82.—COMPARISON OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH THREE CHILDREN WITHOUT CHILD CARE EXPENSES: SELECTED YEARS

	Wages (as a percent of poverty threshold)				
	0	50	75	100	125
Wages (1990 dollars):	0	6,680	10,020	13,360	16,700
Average disposable income (1990 dollars):					
1972	11,199	14,490	15,809	17,058	18,425
1976	10,928	14,409	15,673	16,460	17,412
1980	9,426	12,712	14,041	14,721	15,744
1984	8,751	10,408	11,559	13,061	14,465
1985	8,862	10,892	11,759	13,071	14,865
1986	8,967	10,996	11,826	13,167	14,991
1987	8,828	11,118	12,252	13,646	15,110
1988	8,862	11,225	12,571	14,444	15,345
1989	8,648	11,044	12,499	14,352	15,293
1990	8,684	11,070	12,606	14,454	15,216
1990P	8,684	11,805	13,355	14,997	15,496
Percentage change:					
1972–1990	−22.5	−23.6	−20.3	−15.3	−17.4
1980–1990	−7.9	−12.9	−10.2	−1.8	−3.4
1984–1990	−0.8	6.4	9.1	10.7	5.2
1988–1990	−2.0	−1.4	−0.3	0.1	−0.8
Number of States which supplement wages with AFDC:					
1972	49	49	47	42	35
1980	49	46	36	27	13
1984	49	21	5	0	0
1990	49	26	4	0	0
Number of States with disposable income above poverty:					
1972	7	28	41	49	49
1976	3	35	45	49	49
1980	0	13	31	49	49
1984	0	0	0	0	49
1990	0	2	2	49	49
Average tax rate (in percent):					
1972	NA	51	39	45	48
1980	NA	51	38	48	53
1984	NA	75	57	57	57
1990	NA	64	46	46	52
1990P	NA	60	44	46	55

NA: Not applicable.

P: Projected based on current law.

Note: Disposable income is wages plus AFDC plus food stamps less federal income taxes and payroll taxes. Income is a weighted average across states. 1990P assumes a fully phased-in EITC. Dollars are adjusted for inflation using CPI–U.

Source: Ways and Means Committee and staff based upon CRS state AFDC benefit levels.

Table 83 is analogous to table 82, calculated for a mother with two children. Table 84 and chart 14 present the composition of average disposable income at various wage levels for a family of three with no child care expenses. Table 85 also presents disposable income calculations for a mother with two children, but child care expenses have been included. Table 83 shows that mothers with earnings of $7,814, which are slightly greater than full-time earnings at the minimum wage (75 percent of the Federal poverty level), have had significant reductions in disposable income from 1972 to 1990 (23 percent). In 1972, this same family's disposable income was greater than the poverty threshold in almost all States when AFDC and food stamp benefits were added to wages. In 1990, however, only five states had disposable income above the Federal poverty level. Average tax rates on earnings increased from 52 to 69 percent from 1972 to 1984, and then fell to 60 percent in 1990.

Chart 14 and table 84 show the composition of income at various wage levels for a family of three for selected years. It is clear that total income for these families has fallen at all wage levels shown. This is due primarily to the large decreases in AFDC payments since 1972.

The significant feature of table 85 is the percentage of child care reimbursed by the combination of AFDC, food stamp and Federal tax policies. This assumes that child care is not directly reimbursed by title XX or a similar program, but that the day care expenses are taken into account when computing AFDC and food stamp benefits and Federal tax liability. For a mother with earnings at 75 percent of poverty, these policies combined to reimburse 94 percent of day care expenses in 1972. By 1984, the percentage reimbursed had fallen to 46 percent, primarily because the number of States supplementing wages with AFDC had fallen from 49 to 11. In 1988, the percentage reimbursed had increased to 55 percent.

TABLE 83.—COMPOSITION OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH TWO CHILDREN WITHOUT CHILD CARE EXPENSES: SELECTED YEARS

	Wages (as a percent of poverty threshold)					
	0	50	75	90	100	125
Wages (1990 dollars)	0	5,210	7,814	9,377	10,419	13,024
Average disposable Income (in 1990 dollars):						
1972	9,744	12,414	13,492	14,097	14,482	15,471
1976	9,077	11,921	13,156	13,867	14,137	14,864
1980	7,814	10,432	11,704	12,273	12,513	13,189
1984	7,251	8,587	9,652	10,242	10,700	11,883
1985	7,352	9,115	9,932	10,408	10,807	11,933
1986	7,443	9,213	10,018	10,469	10,857	12,001
1987	7,332	9,247	10,333	11,035	11,478	12,696
1988	7,355	9,352	10,399	11,219	11,854	13,166
1989	7,217	9,218	10,295	11,163	11,805	13,080
1990	7,227	9,202	10,348	11,235	11,916	13,149
1990P	7,227	9,775	11,097	11,984	12,666	13,718
Percentage change:						
1972–1990	−25.8	−25.9	−23.3	−20.3	−17.7	−15.0
1980–1990	−7.5	−11.8	−11.6	−8.5	−4.8	−0.3
1984–1990	−0.3	7.2	7.2	9.7	11.4	10.7
1988–1990	−1.7	−1.6	−0.5	0.1	0.5	−0.1
Number of States which supplement wages with AFDC:						
1972	49	49	49	46	45	40
1980	49	47	42	35	33	20
1984	49	25	7	1	1	0
1990	49	37	6	2	0	0
Number of States with disposable income above poverty:						
1972	19	40	46	49	49	49
1976	11	40	49	49	49	49
1980	0	21	36	49	49	49
1984	0	2	1	1	49	49
1990	0	5	5	49	49	49
Average tax rate (in percent):						
1972	NA	49	52	54	55	56
1980	NA	50	50	52	55	59
1984	NA	74	69	68	67	64
1990	NA	62	60	57	55	55
1990P	NA	51	50	49	48	50

NA Not applicable.

P: Projected based on current law.

Note: Disposable income is wages plus AFDC plus food stamps less federal income and payroll taxes. Income is a weighted average across states. 1990P assumes a fully phased-in EITC. Dollars are adjusted for inflation using CPI–U.

Source: Ways and Means Committee staff and based upon CRS AFDC state benefit levels.

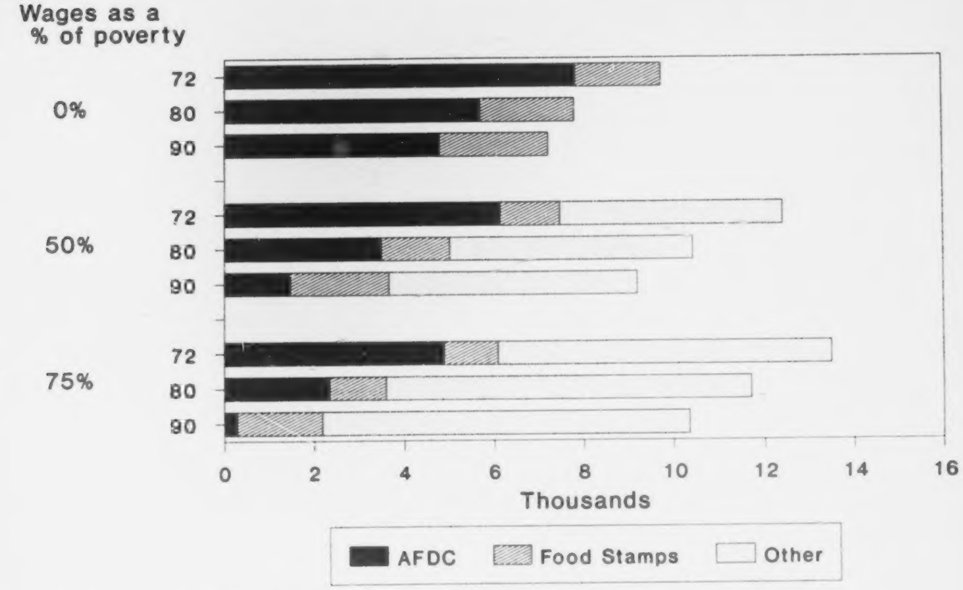
TABLE 84.—COMPOSITION OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH TWO CHILDREN WITHOUT CHILD CARE EXPENSES: 1972, 1980, AND 1990

Wages	1990 dollars			Percent change 1972–90	Percent composition		
	1972	1980	1990		1972	1980	1990
$0 (0 percent FPL):							
AFDC	7,836	5,699	4,801	−39	80	73	66
Foods stamps	1,908	2,115	2,426	27	20	27	34
Disposable income	9,744	7,814	7,227	−26	100	100	100
$5,210 (50 percent FPL):							
Wages	5,210	5,210	5,210	0	42	50	57
AFDC	6,140	3,490	1,475	−76	50	34	16
Foods stamps	1,335	1,530	2,187	64	10	15	24
EITC	0	521	729	NA	0	5	8
Federal taxes	−271	−319	−399	47	−2	−3	−4
Disposable income	12,414	10,432	9,202	−26	100	100	100
$7,814 (75 percent FPL):							
Wages	7,814	7,814	7,814	0	58	67	76
AFDC	4,895	2,335	284	−94	36	20	3
Foods stamps	1,189	1,253	1,895	59	9	11	18
EITC	0	781	953	NA	0	7	9
Federal taxes	−406	−479	−598	47	−3	−4	−6
Disposable income	13,492	11,704	10,348	−23	100	100	100
$10,419 (100 percent FPL):							
Wages	10,419	10,419	10,419	0	72	83	87
AFDC	3,563	1,449	0	−100	25	12	0
Foods stamps	1,043	883	1,341	29	7	7	11
EITC	0	681	953	NA	0	5	8
Federal taxes	−543	−919	−797	47	−4	−7	−7
Disposable income	14,482	12,513	11,916	−18	100	100	100
$13,024 (125 percent FPL):							
Wages	13,024	13,024	13,024	0	84	99	99
AFDC	2,499	794	0	−100	16	6	0
Foods stamps	897	485	716	−20	6	4	5
EITC	0	356	724	NA	0	3	6
Federal taxes	−949	−1,470	−1,315	39	−6	−11	−10
Disposable income	15,471	13,189	13,149	−15	100	100	100

Note: Disposable income is wages plus AFDC plus food stamps less Federal income and payroll taxes. Income is a weighted average across States. Dollars are adjusted for inflation using CPI–U. FPL is Federal poverty level

Source: Ways and Means Committee staff and based upon CRS State AFDC benefit levels.

CHART 14. COMPOSITION OF INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER AND TWO CHILDREN FOR SELECTED YEARS (1990 DOLLARS)



Source: Committee on Ways and Means

TABLE 85.—COMPARISON OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH TWO CHILDREN WITH CHILD CARE EXPENSES: SELECTED YEARS

	Wages (as a percent of poverty threshold)					
	0	50	75	90	100	125
Wages (1990 dollars)	0	5,210	7,814	9,377	10,419	13,024
Average disposable income (1990 dollars):						
1972	9,744	12,331	13,402	13,980	14,317	15,200
1976	9,077	11,843	13,073	13,719	13,928	14,573
1980	7,814	10,366	11,363	11,811	12,027	12,583
1984	7,251	8,315	8,807	9,161	9,574	10,813
1985	7,352	8,979	9,422	9,698	10,050	11,152
1986	7,443	9,088	9,496	9,764	10,101	11,219
1987	7,332	9,134	9,701	10,027	10,402	11,778
1988	7,355	9,251	9,768	10,224	10,695	12,088
1989	7,217	9,107	9,653	10,124	10,618	12,030
1990	7,227	9,073	9,638	10,166	10,685	12,129
1990P	7,227	9,646	10,387	10,915	11,435	12,698
Percentage change:						
1972–1990	−25.8	−26.4	−28.1	−27.3	−25.4	−20.2
1980–1990	−7.5	−12.5	−15.2	−13.9	−11.2	−3.6
1984–1990	−0.3	9.1	9.4	11.0	11.6	12.2
1988–1990	−1.7	−1.9	−1.3	−0.6	−0.1	0.3
Number of States which supplement wages with AFDC:						
1972	49	49	49	49	49	46
1980	49	49	49	46	44	34
1984	49	36	11	9	6	1
1990	49	45	21	10	4	0
Number of States with disposable income above poverty:						
1972	19	37	45	47	49	49
1976	11	37	46	49	49	49
1980	0	21	35	38	42	49
1984	0	1	0	0	1	49
1990	0	5	5	5	49	49
Average tax rate (in percent):						
1972	NA	50	53	55	56	58
1980	NA	51	55	57	60	63
1984	NA	80	80	80	78	73
1990	NA	65	69	69	67	62
1990P	NA	54	60	61	60	58
Percentage of childcare reimbursed:						
1972	NA	92	94	94	91	86
1976	NA	93	95	92	89	85
1980	NA	94	78	75	75	68
1984	NA	74	46	42	41	44
1990	NA	88	55	43	36	47

NA: Not applicable.

P: Projected based on current law.

Note: Disposable income is wages plus AFDC plus food stamps less Federal income and payroll taxes. Income is a weighted average across States. 1990P assumes a fully phased-in EITC. Dollars are adjusted for inflation using CPI–U.

Source: Committee on Ways and Means based upon CRS State AFDC benefit levels.

Table 86 shows the average disposable income and the average AFDC payments for a mother with two children at two wage levels with various child support payments. For example, a mother with wages equal to 50 percent of the poverty level who receives $1,200 in child support would receive $1,069 in AFDC yielding a total disposable income of $10,322. This mother is made better off by $547 compared to a similar mother receiving no child support benefits. In other words, the mother retains 45.6 percent of the father's child support payment with the balance remaining with the State. At both wage levels shown here, particularly for women with no income, higher child support payments yield minimal payoff for the mother, offering little incentive for her to pursue her monthly payments from the absent father.

TABLE 86.—AVERAGE DISPOSABLE INCOME AND AFDC PAYMENTS FOR A MOTHER WITH TWO CHILDREN WITH WAGE LEVELS AT 0 PERCENT AND 50 PERCENT OF THE POVERTY LEVEL GIVEN VARIOUS CHILD SUPPORT PAYMENTS

Wages as a percent of poverty level	Child support payment				
	0	$1200	$2400	$3600	$4800
Total disposable income:					
0 percent (FPL)	$7,227	$7,695	$7,770	$7,867	$8,060
50 percent (FPL)	9,775	10,322	10,768	11,371	12,093
AFDC:					
0 percent (FPL)	4,801	4,253	3,158	2,096	1,178
50 percent (FPL)	1,475	1,069	523	203	40
Average percent of child support retained by the mother:					
0 percent (FPL)	NA	39.0	22.6	17.8	17.4
50 percent (FPL)	NA	45.6	41.4	44.3	48.3
Marginal percent of child support retained by the mother:					
0 percent (FPL)	NA	39.0	3.1	2.7	4.0
50 percent (FPL)	NA	45.6	18.6	16.8	15.0

Note: FPL is the Federal Poverty Level.
NA is not applicable.
Source: Committee on Ways and Means.

Tables 87 and 88 present a State-by-State analysis of the changes from 1972 to 1990 in AFDC and food stamp benefits, and the resulting changes in total disposable income. Benefits in both tables were calculated for a family of three. Data is provided for three wage levels: wages equaling 0, 50, and 75 percent of the poverty level. For a mother with two children, the poverty threshold in 1990 is $10,419. The examples assume no child care expenses. All dollar values are given in 1990 dollars and were adjusted using CPI-U.

Column one of table 88 shows the percentage change in AFDC benefits from 1972 to 1990 for a mother with two children with no income. Over that time period, real AFDC benefits decreased by a weighted national average of 39 percent from $7,836 to $4,801. Nine States showed decreases of at least 50 percent—Alabama, Idaho, Kansas, Kentucky, Michigan, Oregon, South Dakota, Virginia, and West Virginia. Only two States—Georgia and Mississippi—showed a small decrease in benefits, and these States have very low benefit levels compared with national averages.

Column two shows the percentage change in total income, comprised of AFDC and food stamps, from 1972 to 1990 for a mother with two children with no income. Total income decreased by a weighted average of 26 percent. The percentage change varied from an 8 percent decrease in total income in Mississippi to a 40 percent decrease in Idaho, with every state showing a decrease in total income. In all States, AFDC benefits decreased by a greater percentage than total income. This indicates that as the Federal Government increased the food stamp benefits, States undercut the increase by decreasing state-funded AFDC benefits. Or stated alternatively, in real terms states failed to keep AFDC benefit levels up with inflation.

Column three shows the average tax rate in 1972 for a mother with two children with earnings between $0 and $5,210. The national average was a rate of 49 percent.

Column four shows the same tax rate in 1990. The national average increased slightly to a rate of 62 percent.

While all States supplemented wages equal to 50 percent of poverty in 1972, in 1990 twelve States have discontinued AFDC benefits for three-person families with earnings equal to $5,210 (50 percent of poverty). This was primarily the result of the 1981 Federal AFDC earnings disregard changes.

Of the 39 jurisdictions in 1988 that awarded any AFDC benefits at earnings equal to $4,714, the typical tax rate was 68 percent. However, eight jurisdictions, namely Colorado, Georgia, Maine, Michigan, Mississippi, South Carolina, Tennessee, and Utah, have found a way to reduce the implications of the Federal law and have achieved tax rates below 69 percent. For example, Mississippi has a tax rate of 26 percent, followed by Tennessee at 22 percent and Maine at 29 percent.

Column five shows the average AFDC tax rate for a mother with two children with earned income between $0 and $5,210. A 100 percent tax rate would mean that AFDC is reduced one dollar for every additional dollar of earned income. Most States have AFDC tax rates in the 62–72 percent range, with the national average 64 percent.

Columns six and seven show the marginal tax rates for 1972 and 1990 for a mother with two children with earned income between 50 and 75 percent of the poverty level. In 1972 the weighted national average was 59 percent; by 1990 it had fallen to 49 percent. Five States had marginal income tax rates of over 90 percent. In other words, if a mother were to increase her earnings by $3,000, her disposable income would actually increase by less than $300 in these States. This does not take into account any additional work expenses or the fact that increasing earnings might lead to the loss of Medicaid benefits.

Columns eight and nine show the percent change in total disposable income between 1972 and 1990 for a mother with two children and earned income of 50 and 75 percent of the poverty level, respectively. At both wage earning levels almost every State showed a decrease in total income over the time period, with average decreases 26 percent for earnings of $5,210 (50 percent of poverty) and 23 percent for earnings of $7,814 (75 percent of poverty).

TABLE 87.—AFDC AND DISPOSABLE INCOME FOR A MOTHER AND TWO CHILDREN WITHOUT CHILDCARE AT VARIOUS WAGE LEVELS FOR 1972 AND 1990, BY STATE (IN 1990 DOLLARS)

[Wages as a percent of Federal poverty level]

State	AFDC						Disposable income					
	0 percent		50 percent		75 percent		0 percent		50 percent		75 percent	
	1972	1990	1972	1990	1972	1990	1972	1990	1972	1990	1972	1990
Alabama	3,400	1,416	1,466	0	125	0	6,611	4,536	8,871	8,132	9,739	10,136
Arizona	5,163	3,516	3,802	0	2,858	0	7,845	6,303	10,506	8,132	11,652	10,136
Arkansas	3,935	2,448	3,935	0	3,935	0	6,986	5,555	10,599	8,132	12,406	10,136
California	10,042	8,328	8,108	4,559	6,767	1,954	11,261	9,671	13,946	11,323	15,074	11,503
Colorado	7,146	4,272	5,212	1,087	3,871	0	9,233	6,832	11,493	8,893	12,361	10,136
Connecticut	10,955	8,160	9,021	4,391	7,680	1,786	11,900	9,554	14,859	11,205	15,986	11,386
Delaware	7,713	3,996	5,779	227	4,437	0	9,630	6,639	11,890	8,290	12,757	10,136
District of Columbia	8,090	4,908	6,157	1,139	4,815	0	9,894	7,277	12,154	8,929	13,122	10,136
Florida	4,533	3,528	2,599	0	1,258	0	7,404	6,311	9,664	8,132	10,532	10,136
Georgia	3,620	3,276	2,775	1,199	1,876	0	6,765	6,135	9,787	8,971	10,965	10,136
Idaho	9,444	3,804	7,510	0	6,169	0	10,842	6,505	13,348	8,132	14,475	10,136
Illinois	8,216	4,404	6,283	635	4,941	0	9,983	6,989	12,242	8,641	13,248	10,136
Indiana	6,296	3,456	6,296	0	5,413	0	8,638	6,261	12,252	8,132	13,720	10,136
Iowa	9,255	5,112	7,321	1,343	5,980	0	10,710	7,420	13,159	9,072	14,287	10,136
Kansas	10,420	4,908	8,486	1,139	7,145	0	11,525	7,407	14,323	9,058	15,451	10,136
Kentucky	5,824	2,736	3,890	1,398	2,549	0	8,308	5,757	10,568	9,111	11,435	10,136
Louisiana	4,029	2,280	2,096	0	754	0	7,052	5,400	9,312	8,132	10,179	10,136
Maine	6,957	5,436	5,023	4,055	3,682	1,450	9,101	7,647	11,361	10,970	12,229	11,151

TABLE 87.—AFDC AND DISPOSABLE INCOME FOR A MOTHER AND TWO CHILDREN WITHOUT CHILDCARE AT VARIOUS WAGE LEVELS FOR 1972 AND 1990, BY STATE (IN 1990 DOLLARS)—Continued

[Wages as a percent of Federal poverty level]

State	AFDC						Disposable income					
	0 percent		50 percent		75 percent		0 percent		50 percent		75 percent	
	1972	1990	1972	1990	1972	1990	1972	1990	1972	1990	1972	1990
Maryland	6,296	4,872	4,362	1,103	3,021	0	8,638	7,465	10,898	9,116	11,766	10,136
Massachusetts	10,325	6,468	8,392	2,699	7,050	0	11,459	8,369	14,229	10,021	15,357	10,136
Michigan (Wayne)	10,609	5,304	8,675	1,535	7,334	0	11,657	7,555	14,512	9,206	15,640	10,136
Minnesota	10,388	6,384	8,455	2,615	7,113	0	11,503	8,311	14,292	9,962	15,420	10,136
Mississippi	1,511	1,440	1,511	388	1,511	0	4,956	4,560	8,902	8,403	10,709	10,136
Missouri	4,250	3,504	4,250	0	4,250	0	7,206	6,295	10,819	9,132	12,626	10,136
Montana	6,957	4,440	5,023	671	3,682	0	9,101	6,950	11,361	8,601	12,229	10,136
Nebraska	7,933	4,368	6,881	599	5,539	0	9,784	6,899	12,718	8,551	13,846	10,136
Nevada	6,548	3,960	4,614	191	3,273	0	8,815	6,614	11,074	8,265	11,942	10,136
New Hampshire	9,696	6,072	7,762	2,303	6,421	0	11,018	8,092	13,599	9,744	14,727	10,136
New Jersey	9,759	5,088	7,825	1,319	6,484	0	11,062	7,493	13,662	9,145	14,790	10,136
New Mexico	5,320	3,720	3,670	0	2,517	0	7,955	6,446	10,414	8,705	11,413	10,885
New York (NYC)	12,403	6,924	10,469	3,155	9,128	550	1,3,302	8,879	16,307	11,104	17,435	11,435
North Carolina	5,761	3,264	3,827	0	2,486	0	8,264	6,127	10,524	8,705	11,391	10,885
North Dakota	9,507	4,812	7,573	1,043	6,232	0	10,886	7,210	13,411	9,435	14,538	10,885
Ohio	6,422	4,008	4,488	239	3,147	0	8,727	6,698	10,986	8,922	11,854	10,885
Oklahoma	7,303	3,900	5,370	131	4,028	0	9,344	6,572	11,603	8,796	12,471	10,885

Oregon	11,144	5,328	9,210	1,559	7,869	0	12,043	7,996	15,047	10,221	16,175	10,885
Pennsylvania	9,979	5,052	8,045	1,283	6,704	0	11,217	7,378	13,883	9,603	15,011	10,885
Rhode Island	9,885	6,516	7,951	2,747	6,610	142	11,151	8,464	13,788	10,689	14,916	11,027
South Carolina	3,022	2,472	3,022	622	2,328	0	6,347	5,572	9,960	9,140	11,281	10,885
South Dakota	9,224	4,620	7,290	851	5,949	0	10,688	7,076	13,127	9,300	14,255	10,885
Tennessee	3,620	2,340	3,620	1,175	2,360	0	6,765	5,460	10,379	9,527	11,303	10,885
Texas	3,652	2,208	1,718	0	377	0	6,787	5,328	9,047	8,705	9,915	10,885
Utah	8,657	4,644	6,723	1,817	5,382	0	10,291	7,093	12,561	9,977	13,688	10,885
Vermont	10,483	7,944	8,549	4,175	7,208	1,570	11,569	9,403	14,386	11,627	15,514	11,984
Virginia	8,437	4,248	6,503	479	5,162	0	10,137	6,815	12,397	9,040	13,468	10,885
Washington	10,325	6,012	8,392	2,243	7,050	0	11,459	8,252	14,229	10,476	15,357	10,885
West Virginia	6,485	2,988	4,551	0	3,210	0	8,771	5,933	11,030	8,705	11,890	10,885
Wisconsin	11,238	6,204	9,305	2,435	7,963	0	12,137	8,185	15,142	10,409	16,270	10,885
Wyoming	7,713	4,320	5,779	551	4,437	0	9,630	6,866	11,890	9,090	12,757	10,885
Average	7,549	4,478	5,910	1,206	4,695	152	9,517	6,991	12,174	9,005	13,257	10,246
Weighted Average	7,836	4,801	6,140	1,475	4,895	284	9,744	7,227	12,414	9,202	13,492	10,348

Source: Committee on Ways and Means.

TABLE 88.—CHANGES IN BENEFIT LEVELS AND TOTAL INCOME FOR A MOTHER AND TWO CHILDREN AT VARIOUS EARNINGS LEVELS BETWEEN 1972 AND 1990, BY STATE

[Derived from table 87]

	Percent change in AFDC, 1972–90	Percent change in AFDC and food stamps, 1972–90	Average tax rate [1]		Average AFDC tax rate, 1990	Marginal tax rate [1]		Percent change total income, 1972–90	
			1972	1990		1972	1990	Wages=$5,210	Wages=$7,814
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Alabama	−58	−31	57	31	27	67	23	−8	4
Arizona	−32	−20	49	65	67	56	23	−23	−13
Arkansas	−38	−20	31	51	47	31	23	−23	−18
California	−17	−14	48	68	72	57	93	−19	−24
Colorado	−40	−26	57	60	61	67	52	−23	−18
Connecticut	−26	−20	43	68	72	57	93	−25	−29
Delaware	−48	−31	57	68	72	67	29	−30	−21
District of Columbia	−39	−26	57	68	72	63	54	−27	−23
Florida	−22	−15	57	65	68	67	23	−16	−4
Georgia	−10	−9	42	46	40	55	55	−8	−8
Idaho	−60	−40	52	69	73	57	23	−39	−30
Illinois	−46	−30	57	68	72	61	43	−29	−23
Indiana	−45	−28	31	64	66	44	23	−34	−26
Iowa	−45	−31	53	68	72	57	59	−31	−29
Kansas	−53	−36	46	68	72	57	59	−37	−34
Kentucky	−53	−31	57	36	26	67	61	−14	−11

Louisiana	−43	−23	57	48	44	67	23	−13	−0
Maine	−22	−16	57	36	27	67	93	−3	−9
Maryland	−23	−14	57	68	72	67	61	−16	−14
Massachusetts	−37	−27	47	68	72	57	96	−30	−34
Michigan	−50	−35	45	68	72	57	64	−37	−35
Minnesota	−39	−28	46	68	72	57	93	−30	−34
Mississippi	−5	−8	24	26	20	31	33	−6	−5
Missouri	−18	−13	31	46	67	31	61	−16	−20
Montana	−36	−24	57	68	72	67	41	−24	−17
Nebraska	−45	−29	44	68	72	57	39	−33	−27
Nevada	−40	−25	57	68	72	67	28	−25	−15
New Hampshire	−37	−27	50	68	72	57	85	−28	−31
New Jersey	−48	−32	50	68	72	57	62	−33	−31
New Mexico	−30	−19	53	57	71	62	16	−16	−5
New York	−44	−33	42	57	72	57	87	−32	−34
North Carolina	−43	−26	57	51	63	67	16	−17	−4
North Dakota	−49	−34	52	57	72	57	44	−30	−25
Ohio	−38	−23	57	57	72	67	25	−19	−8
Oklahoma	−47	−30	57	57	72	67	20	−24	−13
Oregon	−52	−34	42	57	72	57	75	−32	−33
Pennsylvania	−49	−34	49	57	72	57	51	−31	−27
Rhode Island	−34	−24	49	57	72	57	87	−22	−26
South Carolina	−18	−12	31	32	36	49	33	−8	−4
South Dakota	−50	−34	53	57	72	57	39	−29	−24
Tennessee	−35	−19	31	22	22	65	48	−8	−4
Texas	−40	−21	57	35	42	67	16	−4	10
Utah	−46	−31	56	45	54	57	65	−21	−20

TABLE 88.—CHANGES IN BENEFIT LEVELS AND TOTAL INCOME FOR A MOTHER AND TWO CHILDREN AT VARIOUS EARNINGS LEVELS BETWEEN 1972 AND 1990, BY STATE—Continued

[Derived from table 87]

	Percent change in AFDC, 1972–90	Percent change in AFDC and food stamps, 1972–90	Average tax rate [1]		Average AFDC tax rate, 1990	Marginal tax rate [1]		Percent change total income, 1972–90	
			1972	1990		1972	1990	Wages=$5,210	Wages=$7,814
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Vermont	−24	−19	46	57	72	57	86	−19	−23
Virginia	−50	−33	57	57	72	59	29	−27	−19
Washington	−42	−28	47	57	72	57	84	−26	−29
West Virginia	−54	−32	57	47	57	67	16	−21	−8
Wisconsin	−45	−33	42	57	72	57	82	−31	−33
Wyoming	−44	−29	57	57	72	67	31	−24	−15
Average	−41	−27	49	61	63	58	52	−26	−23
Weighted average	−39	−26	49	62	64	59	56	−26	−23

[1] See text for definition of average and marginal tax rates.

Source: Committee on Ways and Means.

STUDY METHODOLOGY

AFDC

Each State's AFDC program was modeled using the appropriate need standard, payment standard, ratable reduction (usually 100 percent), and maximum benefit for July of each year from 1972 to 1990 for families of three and four. Data for 1972 for a family of three was derived by assuming that the relationship in the payment standard for a family of three and a family of four was the same in 1972 as it was in 1976. Actual data do not exist for three-person families prior to 1976.

All of the AFDC benefit amounts from 1960 to 1968 are from a series of HEW publications entitled: "State Maximums and Other Methods of Limiting Money Payments to Recipients Under Special Types of Public Assistance," September 1960 and October 1968; or "Monthly Cost Standards Used by States for Specified Types of Old Age Assistance Cases and Families Receiving Aid to Families with Dependent Children," January 1961 and January 1965. The AFDC benefit listed in table 81 for 1960 is the January 1961 benefit amount, to which was applied the State maximum AFDC payment amounts in effect for September 1960. Data for 1964 are the January 1965 benefit. The benefit level for 1968 is for the month of April. Data for 1972 to 1990 were provided by the Congressional Research Service. The earlier year data (1960 to 1968) are of lower quality than data for 1972 on. However, the general trends noted in table 81 for 1960 to 1968 are correct.

AFDC benefits are calculated in the fifth month of eligibility since the majority of female heads with wages are not in their first 4 months of employment. In 1990, the earnings disregard equals $120 a month (a standard work expense disregard of $90 and a $30 income disregard applied during the first 12 months of eligibility). (For additional data on disregards, see table 1 in section 7.) Note that work and income disregards are not affected by family size.

The benefit in each State for an AFDC family in its fifth month of eligibility is computed through a four-step process, which is described below. Table 89 presents an example of the calculations for a mother and two children in 1990, with earnings at 50 percent of the poverty threshold.

Step 1: Compute monthly earnings. If monthly earnings are greater than 185 percent of the State need standard, the AFDC benefit equals $0 (zero).

Step 2: Compute monthly countable income. Subtract the monthly total disregard of $120, which includes a standard work expense disregard of $90 plus a $30 income disregard.

Step 3: The AFDC benefit is equal to the State payment standard minus countable income, multiplied by the ratable reduction (which equals 1 in most States), subject to the constraint that the benefit may not exceed the State maximum payment.

Step 4: If the calculated AFDC benefit is less than $10 per month, the actual AFDC benefit equals $0 (zero).

The energy disregard is not used in computing AFDC benefits, but is subtracted from AFDC prior to including AFDC income in the food stamp formula.

TABLE 89.—AFDC BENEFIT FORMULAS FOR EACH STATE, FOR A MOTHER WITH TWO CHILDREN AND MONTHLY EARNINGS OF $434 IN JULY OF 1990

State	Needs standard	Payment standard	Maximum payment	Rateable reduction	Energy disregard	Monthly AFDC benefit
Alabama	578	118	118	1.0	0	0
Arizona	621	293	293	1.0	0	0
Arkansas	705	204	204	1.0	0	0
California	694	694	694	1.0	0	380
Colorado	421	421	356	0.8475	0	91
Connecticut	680	680	680	1.0	0	366
Delaware	333	333	333	1.0	0	19
District of Columbia	712	409	409	1.0	0	95
Florida	880	294	294	1.0	0	0
Georgia	414	414	273	1.0	0	100
Idaho	554	317	317	1.0	0	0
Illinois	777	367	367	1.0	18	53
Indiana	320	288	288	1.0	0	0
Iowa	497	426	426	1.0	0	112
Kansas	409	409	409	1.0	36	95
Kentucky	526	526	228	0.5500	0	117
Louisiana	658	190	190	1.0	0	0
Maine	652	652	453	1.0	0	338
Maryland	562	406	406	1.0	59	92
Massachusetts	539	539	539	1.0	0	225
Michigan (Wayne Co.)	575	442	442	1.0	0	128
Minnesota	532	532	532	1.0	0	218
Mississippi	368	368	120	0.6000	0	32
Missouri	312	292	292	1.0	0	0
Montana	453	370	370	1.0	0	56
Nebraska	364	364	364	1.0	0	50
Nevada	550	330	330	1.0	0	16
New Hampshire	506	506	506	1.0	0	192
New Jersey	424	424	424	1.0	25	110
New Mexico	310	310	310	1.0	0	0
New York (N.Y.C.)	577	577	577	1.0	53	263
North Carolina	544	272	272	1.0	0	0
North Dakota	401	401	401	1.0	0	87
Ohio	776	334	334	1.0	14	20
Oklahoma	471	325	325	1.0	0	11
Oregon	444	444	444	1.0	118	130
Pennsylvania	614	421	421	1.0	0	107

TABLE 89.—AFDC BENEFIT FORMULAS FOR EACH STATE, FOR A MOTHER WITH TWO CHILDREN AND MONTHLY EARNINGS OF $434 IN JULY OF 1990—Continued

State	Needs standard	Payment standard	Maximum payment	Rateable reduction	Energy disregard	Monthly AFDC benefit
Rhode Island	543	543	543	1.0	17	229
South Carolina	419	419	206	0.4940	0	52
South Dakota	385	385	385	1.0	0	71
Tennessee	412	412	195	1.0	0	98
Texas	574	184	184	1.0	0	0
Utah	516	516	387	0.7500	0	151
Vermont	973	662	662	1.0	0	348
Virginia	393	354	354	1.0	0	40
Washington	907	501	501	1.0	56	187
West Virginia	497	249	249	1.0	0	0
Wisconsin	647	517	517	1.0	0	204
Wyoming	360	360	360	1.0	0	46

Food stamps

Given a wage and AFDC benefit level, the food stamp benefit is calculated using the July food stamp parameters for the designated year, which vary by family size (see table 89).

Earned income tax credit

For further discussion on the EITC, see section 12.

Federal income taxes

Federal income taxes are calculated using the head of household tax rates, with a standard deduction and exemptions equal to the number of family members.

Federal payroll taxes

Only FICA payroll taxes are included. The tax rate percentage is 5.20, 5.85, 6.13, 6.70, 7.05, 7.15, 7.15, 7.51, 7.51, and 7.65 of wages in 1972, 1976, 1980, 1984, 1985, 1986, 1987, 1988, 1989, and 1990 respectively.

Day care expenses

Day care expenses are assumed to be 20 percent of wages up to a maximum of $100 per month (1979 dollars). This was the average deduction in AFDC for those families with child care expenses. This maximum was then inflated or deflated to the appropriate year using the Consumer Price Index.

Additional comments

The above methodology did not incorporate any other sources of income or expenses although it is possible that these families could have other income sources. The value of health care benefits—in the form of Medicaid or private health insurance—has not been included. A low-income energy assistance grant also was not assumed. However, several States beginning in 1984 (Maryland, New York, Oregon, Rhode Island, and Washington) have designated a portion of their AFDC grant as energy assistance and this is disregarded in calculating the food stamp benefit. The size of the benefit does not affect the family's eligibility for more energy assistance and the primary effect is to increase food stamp benefits. This energy disregard was modeled when food stamp benefits were calculated.

The section above examines income in the one month of July which is the month in which AFDC benefits are usually increased. The benefit levels are then annualized to examine Federal tax policy. To some extent, this is a simplification of the real world. In some States, AFDC benefits vary by season. Food stamp benefit calculations are different at different times of the year. However, there is no reason to believe that annualizing July data presents a misleading picture of Federal and State policy changes between 1972 and 1990.

Nominal dollars are converted to constant dollars using the CPI-U price index, the same index used to index the poverty thresholds.

1990P

The 1990 projection methodology incorporates the new changes in the calculation of the Earned Income Tax Credit. The phase-in and phase-out percentages are those used for 1994.

TABLE 90.—SUMMARY OF KEY MONTHLY FOOD STAMP PARAMETERS FOR JULY OF EACH MODEL YEAR

	1972	1976	1980	1984	1985	1986	1987	1988	1989	1990
Maximum allotment:										
Family of 3	92	130	165	199	208	211	214	228	236	260
Family of 4	112	166	209	253	264	268	272	290	300	331
Standard deduction	[1]40	[1]55	75	89	95	98	99	102	106	112
Work expenses (as percent of wages)	(2)	(2)	20	18	18	20	20	20	20	20
Monthly shelter deduction	None	None	45	62.5	67	73.5	74.5	82	85	88.5
Countable income limit:										
Family of 3	NA	$433	$520	$705	$738	$760	$775	$775	$808	$839
Family of 4	$390	$570	$621	$825	$888	$917	$934	$934	$971	$1,009
Gross income limit:										
Family of 3	None	None	None	$917	$959	$988	$1,008	$1,008	$1,050	$1,090
Family of 4	None	None	None	$1,073	$1,154	$1,192	$1,214	$1,214	$1,263	$1,311

[1] In addition, the monthly purchase requirement table had a $30 deduction amount built into the table. These amounts include the shelter deduction.

[2] Work expense deduction in 1972 and 1976 equals actual taxes plus 10 percent of wages, up to $275 annually in 1972 and $375 annually in 1976.

NA=Not applicable.

APPENDIX H. DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF THE ELDERLY

This appendix presents selected historical and current data on the demographic and economic characteristics of the elderly. Tables 1 through 20 present characteristics of the overall elderly population, including: population and life expectancy trends; marital status and living arrangements; labor force participation; poverty statistics; and income sources. Data sources are noted at the bottom of each table.

The following definitions may be useful for reading the tables:

(1) "Aged" and "elderly" each refer to any person 65 years old or older.

(2) "OASDI" and "Social Security" are used interchangeably.

(3) "Supplemental security income" is, at times, abbreviated "SSI."

(4) The concepts "unrelated individual" and "unit" are used many times throughout this appendix. "Unrelated individual" refers to any individual living alone. "Unit" refers to an individual living alone, a couple living alone or a family.

POPULATION

The U.S. population is aging. As table 1 illustrates, there has been and will continue to be a dramatic increase in the proportion of the population that is elderly. The elderly represented 6.7 percent of the population in 1940, 11.1 percent in 1980, and are projected to represent 12.7 percent of the population by the year 2000. The actual number of elderly individuals is expected to quadruple between 1940 and 2000, and increase by roughly 36 percent between 1980 and 2000.

The percentages of the population that are 75 and over and 85 and over will grow at a faster rate than the overall elderly population. Between 1980 and 2000, the percentage of the population that is over age 75 is projected to increase from 4.4 to 6.0 percent. The percentage of the population that is age 85 and over is projected to increase from 1.0 to 1.6 percent.

TABLE 1.—ELDERLY POPULATION AS PERCENT OF TOTAL POPULATION AND DISTRIBUTION OF ELDERLY BY AGE AND SEX, SELECTED YEARS 1940 TO 2025, AS OF JULY 1

	1940	1950	1960	1970	1980	1990 [1]	2000 [1]	2025 [1]
Population 65 years and older (in thousands)	9,194	12,706	17,094	20,741	26,118	31,912	35,276	60,456
Population age 65 and older as a percent of total population	6.7	8.0	9.0	9.6	11.1	12.3	12.7	19.2
Population age 75 and older as a percent of total population	2.1	2.7	3.1	3.8	4.4	5.2	6.0	8.0
Population age 85 and older as a percent of total population	.3	.4	.5	.7	1.0	1.3	1.6	2.1
Certain age and sex groupings as a percent of the population 65 years and older:								
Total 65 years and older	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Men 65 and older	48.5	46.8	44.6	41.5	40.3	40.8	41.3	44.0
Men 65 to 74	34.2	32.1	30.4	26.5	26.3	25.9	24.0	27.6
Men 75 to 84	12.5	12.7	12.0	12.5	11.3	12.1	13.8	13.1
Men 85 and older	1.8	2.0	2.2	2.5	2.7	2.8	3.5	3.3
Women 65 and older	51.5	53.2	55.4	58.5	59.7	59.2	58.7	56.0
Women 65 to 74	34.3	34.4	35.6	34.0	33.9	31.9	28.4	30.7
Women 75 to 84	14.5	15.7	16.3	19.6	19.3	19.8	21.3	17.8
Women 85 and older	2.5	3.1	3.5	4.9	6.5	7.5	9.0	7.5

[1] Projection.

Note: Population data for 1940 and 1950 include coterminous U.S. only; 1960 and 1970 refer to total U.S. population; 1980 to 2025 refer to total U.S. plus the outlying areas and include an adjustment for the population undercount.

Source: 1940 to 1970, U.S. Bureau of the Census, U.S. Census of Population, 1940, 1960, and 1970; 1980 to 2025, 1990 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, and unpublished estimates from the Office of the Actuary, Social Security Administration.

TRENDS IN LIFE EXPECTANCY

Table 2 presents data on life expectancies both at birth and at age 65 for men and women. These data cover the historical period 1900 through 1980, and the projected period 1990 through 2080. On average, a female born in 1900 could expect to live 48 years; a female born in 1980 could expect to live more than 77 years. Life expectancies at birth have increased so dramatically primarily because infant and child mortality rates have decreased, but also because individuals who live to adulthood are living longer. A male reaching age 65 in 1900 could expect to live another 11 years on average; a male reaching age 65 in 1980 could expect to live another 14 years. Life expectancies at birth and at age 65 are expected to continue to increase.

TABLE 2.—ACTUAL AND PROJECTED LIFE EXPECTANCIES AT BIRTH AND AT AGE 65 FOR MEN AND WOMEN: 1900–2080

Year	Life expectancy at birth		Life expectancy at age 65	
	Male	Female	Male	Female
Actual:				
1900	46.3	48.3	11.3	12.0
1910	48.4	51.8	11.4	12.1
1920	53.6	54.6	11.8	12.3
1930	58.1	61.6	11.8	12.9
1940	60.8	65.2	11.9	13.4
1950	65.5	71.0	12.7	15.0
1960	66.8	73.2	13.0	15.8
1970	67.0	74.6	13.0	16.8
1980	70.1	77.6	14.2	18.4
Projected (middle mortality assumption):				
1990	72.1	79.0	15.0	19.4
2000	73.5	80.4	15.7	20.3
2010	74.4	81.3	16.2	21.0
2020	74.9	81.8	16.6	21.4
2030	75.4	82.3	17.0	21.8
2040	75.9	82.8	17.3	22.3
2050	76.4	83.3	17.7	22.7
2060	76.8	83.8	18.1	23.1
2080	77.8	84.7	18.8	23.9

Source: 1900 to 1940: At Birth: National Center for Health Statistics. Vital Statistics of the United States, 1980. Vol. II—Mortality. Hyattsville, MD. 1985. At Age 65: Social Security Administration. Social Security Area Population Projections. 1985. Actuarial Study No. 95. SSA Pub. No. 11–11542. October 1985. 1950 to 2080: U.S. Bureau of the Census. Projections of the Population of the United States, by Age, Sex, and Race: 1988 to 2080. Current Population Reports. Series P–25. No. 1018 Washington, DC. January, 1989. Table B–5.

MARITAL STATUS AND LIVING ARRANGEMENTS

Tables 3 and 4 present information on the marital status and living arrangements of noninstitutionalized aged individuals for 1970, 1980 and 1989. Table 3 also includes data for 1960.

Perhaps the most striking statistics are those that apply to elderly women. In each of the 4 years of table 3, roughly 40 percent of elderly women ages 65 to 74, and roughly 70 percent of elderly women ages 75 and over, were widows. The percentage of women who are widowed has decreased in both age groups. However, because the size of the elderly population grew between 1960 and 1989, there are increasing numbers of widowed elderly women in the United States. As shown in table 4 there were 5.9 million widowed women over age 65 in 1970 and 8.3 million by 1989, representing a 41-percent increase.

TABLE 3.—MARITAL STATUS OF AGED INDIVIDUALS,[1] BY SEX AND AGE, 1960, 1970, 1980, AND 1989

	1960		1970[2]		1980[3]		1989	
	65 to 74	75 and over	65 to 74	75 and over	65 to 74	75 and over	65 to 74	75 and over
Men:								
Number (in thousands)	4,778	2,280	5,333	3,031	6,459	3,234	7,880	4,199
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Married, wife present	76.2	56.5	74.6	57.5	79.4	67.7	78.4	66.7
Married, wife absent	2.7	2.6	3.0	4.0	2.2	1.7	2.7	2.7
Widowed	12.7	31.6	11.0	30.4	8.5	24.0	8.9	23.4
Divorced	1.7	1.5	2.9	1.5	4.4	2.2	5.1	2.8
Never married	6.7	7.8	8.5	6.6	5.4	4.4	4.9	4.4
Women:								
Number (in thousands)	5,529	3,054	6,741	4,608	8,549	5,411	9,867	7,077
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Married, husband present	43.5	20.6	43.8	18.9	48.1	22.1	51.4	24.3
Married, husband absent	2.1	1.2	1.6	1.9	2.0	1.2	1.8	1.4
Widowed	44.4	68.3	43.7	70.5	40.3	68.0	36.6	65.6
Divorced	1.7	1.2	3.0	1.3	4.0	2.3	5.7	2.9
Never married[4]	8.4	8.6	7.9	7.4	5.6	6.4	4.5	5.8

[1] Civilian noninstitutional population only.

[2] Estimates based on weights derived from the 1960 decennial census.

[3] Estimates based on weights derived from the 1970 decennial census.

[4] Never married was reported as "single" for 1960.

Note: Details may not add to totals due to rounding.

Source: U.S. Bureau of the Census, Current Population Reports, series P–20, Nos. 135, 212, 365, 423, and 445.

A large and increasing fraction of all noninstitutionalized widowed women live alone. Over 69 percent of widowed women lived alone in 1989, compared with 56 percent in 1970. As a result of this increase, the number of widowed women living alone has grown even faster than the overall number of widowed women. Between 1970 and 1989, the number of widowed women living alone increased 70 percent, from 3.3 to 5.8 million.

TABLE 4.—LIVING ARRANGEMENTS OF PERSONS AGED 65 AND OVER,[1] 1970, 1980, AND 1989

[Civilian noninstitutionalized population, number in thousands]

Living arrangement	Total 65 and over	Percent	Widowed men	Percent	Widowed women	Percent
Total:						
1970 [2]	19,061	100.0	1,333	100.0	5,946	100.0
1980 [3]	24,194	100.0	1,342	100.0	7,295	100.0
1989	29,022	100.0	1,686	100.0	8,260	100.0
In families:						
1970 [2]	13,347	70.0	499	37.4	2,386	40.1
1980 [3]	16,355	67.6	385	28.7	2,194	30.1
1989	19,567	67.4	553	32.8	2,297	27.8
Living alone:						
1970 [2]	5,071	26.6	708	53.1	3,309	55.7
1980 [3]	7,328	30.3	893	66.5	4,916	67.4
1989	8,851	30.5	1,058	62.8	5,752	69.6
Other:						
1970 [2]	645	3.4	124	9.3	251	4.2
1980 [3]	511	2.1	65	4.8	186	2.5
1989	604	2.1	75	4.4	211	2.6

[1] Excludes persons in institutions (nursing homes, etc.). The number of such persons age 65 years and over was estimated to be 0.8 million in 1970, and 1.6 million in 1989.

[2] Estimates based on weights derived from the 1970 decennial census.

[3] Estimates based on weights derived from the 1980 decennial census.

Source: Bureau of the Census, Current Population Reports, P–20, No. 445 and unpublished data.

LABOR FORCE PARTICIPATION

Table 5 presents information on the labor force participation rates of men and women ages 55 and over for selected years between 1950 and 1990. Since 1950, the labor force participation rate for men in this age group has steadily declined. For men ages 55 to 64, the rate has declined from 87 to 68 percent. For men ages 65 and over, the rate has declined from 46 to 16 percent. The trend looks different for women. The participation rate for women ages 55 to 64 has increased from 27 percent in 1950 to 45 percent in 1990. The rate for women ages 65 and over has decreased from 10 percent in 1950 to 9 percent in 1990.

TABLE 5.—CIVILIAN LABOR FORCE PARTICIPATION RATES [1] OF PERSONS 55 YEARS AND OVER, BY AGE AND SEX, SELECTED YEARS, 1950–90

Age	1950	1955	1960	1965	1970	1975	1980	1985	1988	1989	1990
Men:											
55 to 64	86.9	87.9	86.8	84.6	83.0	75.8	72.3	67.9	67.0	67.2	67.7
55 to 59	(2)	92.5	91.6	90.2	89.5	84.4	81.9	79.6	79.3	79.5	79.8
60 to 64	(2)	82.5	81.1	78.0	75.0	65.7	61.0	55.6	54.4	54.8	55.5
60 to 61	(2)	(2)	(2)	84.8	82.6	75.2	71.8	68.9	67.0	68.5	68.8
62 to 64	(2)	(2)	(2)	73.2	69.4	58.8	52.8	46.1	45.4	45.3	46.4
65 and over	45.8	39.6	33.1	27.9	26.8	21.7	19.1	15.8	16.5	16.6	16.4
Women:											
55 to 64	27.0	32.5	37.2	41.4	43.0	41.0	41.5	42.0	43.5	45.0	45.3
55 to 59	(2)	35.6	42.2	47.1	50.4	47.9	48.6	50.3	53.3	54.8	55.3
60 to 64	(2)	29.0	31.4	34.0	36.1	33.3	33.3	33.4	33.8	35.5	35.5
60 to 61	(2)	(2)	(2)	40.4	41.4	39.5	39.8	40.3	41.7	43.3	42.9
62 to 64	(2)	(2)	(2)	29.5	32.3	29.0	28.6	28.7	28.5	30.3	30.7
65 and over	9.7	10.6	10.8	10.0	9.7	8.3	8.1	7.3	7.9	8.4	8.7

[1] Civilian labor force as percent of civilian population.

[2] Data not available.

Source: Monthly Labor Review, November 1979; 1981 Employment and Training Report of the President; January issue of Employment and Earnings; and unpublished data from the Bureau of Labor Statistics.

POVERTY STATUS OF THE ELDERLY [1]

Table 2 in Appendix I shows that the elderly have a lower incidence of poverty than does the population as a whole. In 1988, 12.0 percent of the noninstitutionalized aged were poor, or 3.5 million individuals. This compares to the overall poverty rate of 13.0 percent. In spite of the slightly lower incidence of poverty, poverty rates among the aged vary considerably.

Table 6 presents information on the poverty status of elderly individuals by sex, race and family status. The poverty rate for aged women was almost twice the poverty rate for aged men in 1989. The poverty rate among the black aged was higher in 1989 than that of the white aged—22.1 percent of black aged men and 36.7 percent of black aged women were poor, compared with 6.6 percent of white men and 11.8 percent of white women.

Unrelated aged individuals had much higher poverty rates than aged persons living in families. White unrelated individuals had lower poverty rates than black unrelated individuals.

---

[1] Please see Appendix I for additional poverty data related to the elderly. Appendix I provides details on how poverty is measured, statistics on trends in the overall poverty rate, and comparisons of the poverty rate among selected demographic groups, including the elderly.

TABLE 6.—POVERTY STATUS OF ALL PERSONS, AND THE ELDERLY BY SEX, RACE, AND FAMILY STATUS, SELECTED YEARS: 1959 TO 1989

[Percent below the poverty level]

	1959	1966	1970	1975	1980	1985 [1]	1986	1987	1987 [2] [3]	1988 [3]	1989 [3]
All persons	22.4	14.7	12.6	12.3	13.0	14.0	13.6	13.5	13.3	13.0	12.8
Persons 65 years old and over											
Both sexes	35.2	28.5	24.5	15.3	15.7	12.6	12.4	12.2	12.2	12.0	11.4
Men	NA	23.7	19.0	11.4	10.9	8.5	8.5	8.5	8.4	8.0	7.8
Black men [4]	NA	52.2	41.3	31.0	31.5	26.5	24.2	24.6	23.0	23.7	22.1
Heads of households [5]	60.4	50.0	39.2	26.0	25.0	21.0	19.4	18.7	18.3	19.3	13.7
Unrelated individuals	77.5	72.7	59.7	51.8	45.4	40.6	39.8	42.2	38.2	35.6	43.2
White men [4]	NA	21.3	17.0	9.5	9.0	6.9	6.9	6.8	6.9	6.2	6.6
Heads of households [5]	26.8	18.7	13.8	7.1	6.9	4.9	4.9	5.0	4.9	4.2	5.0
Unrelated individuals	56.8	41.3	36.0	23.8	21.1	17.6	16.7	15.6	16.4	16.5	14.1
Women	NA	32.1	28.4	18.1	19.0	15.6	15.2	14.9	14.9	14.9	14.0
Black women [4]	NA	57.3	53.2	40.2	42.6	34.8	35.5	40.2	38.4	38.0	36.7
Wives [5]	57.7	51.9	41.8	23.8	23.5	17.5	14.4	19.5	17.7	21.1	15.0
Unrelated individuals	84.6	83.9	79.2	65.8	66.6	55.4	59.7	62.8	59.9	56.5	59.8
White women [4]	NA	30.3	26.5	16.1	16.8	13.8	13.3	12.5	12.6	12.6	11.8
Wives [5]	28.9	20.2	14.0	7.2	7.0	4.7	4.7	4.7	4.6	4.0	4.8
Unrelated individuals	61.8	55.2	47.5	29.1	29.3	24.3	23.7	21.9	22.0	22.4	20.2

---

[1] The poverty definition used to produce the estimates for 1981 and years after changed slightly from previous years. If the new method were used for 1980, the heading "All persons" would read 13.2 percent below the poverty level, not 13.0 percent. In 1984, a new method of imputing missing values was utilized and new population weights were used. A comparable number for 1983 of the poverty rate for all persons was 15.4 percent.

[2] Revised 1987 data using the 1988 processing system.

[3] 1987 revised, 1988 and 1989 estimates are not comparable to prior years due to processing changes in the CPS.

[4] Total includes other types of family members not separately designated.

[5] Heads of households defined as "male" reference persons in families. Wives defined as females who are married with spouse present.

NA—Not available.

Sources: U.S. Bureau of the Census, Current Population Reports series P-60 referring to the population below the poverty level, various years in series; unpublished data. The 1986–1989 figures prepared by the Congressional Research Service using the March Current Population Survey computer tapes.

Table 7 presents additional information on the poverty status of the elderly, this time broken down by sex and marital status. This table shows that most of the difference in the incidence of poverty between aged men and aged women appears to be associated with differences in marital status and age. Comparing married men and women, the incidence of poverty is essentially the same at each age. Among aged men, poverty rates are highest among those who are not married and among men ages 85 and over. Among aged women, particularly those over age 74, poverty rates are highest among those who are divorced, separated, or never married, and those who are widowed.

TABLE 7.—POVERTY RATES AMONG PERSONS AGE 65 AND OLDER BY AGE, SEX, AND MARITAL STATUS: 1989

	65 and over	65 to 74	75 to 84	85 and over
Male total	7.8	6.6	9.8	11.3
Married	5.8	4.8	7.4	11.4
Widowed	12.8	12.4	14.4	10.1
Divorced/separated/never married	15.5	13.7	20.6	NA
Female total	14.0	10.6	17.7	22.1
Married	5.9	4.9	8.5	NA
Widowed	18.6	15.2	20.5	23.0
Divorced/separated/never married	23.2	21.0	27.0	NA
Total	11.4	8.8	14.7	18.4

Source: March 1990 Current Population Survey (CPS).
Table prepared by CRS.

NA—Not available due to unreliability of estimate. Percentage base represents fewer than 250,000 persons.

INCOME SOURCES OF THE ELDERLY

As noted in the previous subsection, most elderly individuals had incomes above the poverty threshold in 1989, although a sizeable minority was poor. Tables 9 through 18 provide insight into the sources and distribution of income among the elderly population. The percentage of the aged represented in the various tables is shown below.

TABLE 8.—CHARACTERISTICS OF AGED UNITS: 1990

Description of unit	Number of units (in thousands)	Number of persons age 65 and older (in thousands)	Percent of elderly
All persons in unit age 65 and over	15,745	21,820	69.9
At least one person age 65 or older	22,350	29,566	94.8
Family head age 65 or older	20,562	27,420	87.9
Number of aged not represented by the Current Population Survey		1,632	5.2

Note: Units comprise families and unrelated individuals.

Source: March 1990 Current Population Survey. Table prepared by CRS.

Table 9 provides information for 1989 on the percentage of noninstitutional elderly units (all members ages 65 and over) with income from various sources, broken down by income level. Note that the bottom rows of table 9 present characteristics of persons in elderly units, by income level of the unit. The majority of these units has combined income above the poverty level (84 percent). As one would expect, the fraction of units with income from earnings generally rises as income rises. For example, 4.6 percent of the units with income less than the poverty threshold had income from earnings, compared with 19 percent of the units with income above the poverty threshold. Although overall 95 percent of the units had income from Social Security, only 68 percent of those with income less than 50 percent of the poverty threshold had income from Social Security. Generally, poor elderly units are less likely than nonpoor elderly units to receive income from pensions and from interest and dividends, and more likely to receive income from AFDC, SSI, general assistance, food stamps, and housing assistance.

Table 10 describes the percent of the total income of elderly units that is derived from various sources, broken down by income level. This table shows that 1 percent of total family income for poor units is from earnings, compared with 12.6 percent of nonpoor units. Pension income accounts for 3 percent of total income received by poor units, while it comprises 17.6 percent for nonpoor units. Social Security, SSI, AFDC, and general assistance income together represent 80.9 percent of total income for poor units and approximately 39 percent for nonpoor units. Interest and dividend income represent 3.9 percent of total income for poor units and 28.5 percent for nonpoor units.

Tables 11 and 12 present the same data as tables 9 and 10, but break all units with all members 65 or over into married couples and unrelated individuals, respectively. Table 11 shows that 5.5 percent of all married couples with all members 65 or over are poor. Social Security and railroad retirement provide 78.4 percent of total income for poor elderly couples, while providing only 37.4 percent of total income for nonpoor couples, who also have substantial shares of income from interest and dividends, pensions, and earnings. Table 12 shows that 22.0 percent of unrelated individuals age 65 or over are poor. Almost one-fourth (21.9 percent) of poor elderly unrelated individuals receive housing assistance, which accounts for 8.4 percent of the total income of this group.

Table 13 shows how the demographic characteristics of elderly households with all members age 65 or over and the composition of their incomes have changed between 1979 and 1989. The 1989 data are not comparable to the 1979 data due to processing changes in the CPS. Although the total elderly population is growing—from 12.4 million families in 1979 to 15.7 million families in 1989—the number of poor elderly families has actually decreased over this time period. However, the percentage of elderly poor families in which the head is 75 and over increased significantly, from 48.7 percent in 1979 to 57.6 percent in 1989. The percentage of elderly receiving income from pensions increased for both the poor and the nonpoor, with an increase in receipts from 33 percent in 1979 to 42.8 percent in 1989 for the total elderly population. This increase is also reflected in the increase of the percentage of total income from pensions, from 14.1 percent in 1979 to 17.0 percent in 1989. Over the same time period the percentage of elderly receiving income from AFDC, SSI, and general assistance decreased from 10.0 percent to 6.8 percent. The percentage of all elderly receiving housing assistance has increased. Most significantly, however, is that the percentage of poor elderly receiving housing assistance rose from 11.9 percent in 1979 to 19.7 percent in 1989. This is also reflected in the increase of the percentage of total incomes from housing assistance which rose from 5.4 percent in 1979 to 7.4 percent in 1989. Overall, average income of the total elderly population increased in real terms from $10,916 to $13,850.

Table 14 provides the same data as tables 9 and 10, but with income levels subdivided by cash income in dollars rather than by the ratio of total income to the poverty threshold.

Table 15 is a comparison of elderly units with all members age 65–79 to all members 80 and over. A higher proportion of 80 and over individuals are female. The 80 and over population also has a much smaller proportion of individuals receiving income from earnings and pensions. Their average income is $2,700 less per capita than those age 65–79. Table 16 focuses on units in which *any* member is age 65 or over. Table 17 provides information on the percentage distribution of selected sources of income between poor and nonpoor units in which at least one member is age 65 or over. These data include families with an aged member and elderly individuals living alone.

TABLE 9.—PERCENT OF UNITS [1] WITH ALL MEMBERS AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES, BY POVERTY STATUS,[2] 1989

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Number of units (in thousands)	380	549	1,554	1,618	1,599	2,261	3,111	4,673	2,483	13,262	15,745
Percent of units	2.4	3.5	9.9	10.3	10.2	14.4	19.8	29.7	15.8	84.2	100.0
Earnings [3]	5.5	4.2	4.6	6.2	8.6	11.9	17.8	32.5	4.6	19.4	17.1
OASDI, railroad retirement	67.5	90.1	93.4	96.8	96.8	97.2	97.3	94.2	88.7	96.0	94.9
Pensions	8.6	4.3	9.0	14.0	25.4	41.9	59.0	67.0	7.9	49.4	42.8
Unemployment compensation, workers compensation, veterans payments	2.6	2.9	4.8	8.1	4.6	5.3	5.6	6.9	4.1	6.2	5.9
AFDC, SSI, general assistance	8.6	22.7	31.4	9.9	8.0	2.9	1.5	0.4	26.0	3.2	6.8
Child support, alimony	2.5	1.6	2.6	3.1	2.8	4.3	5.4	4.9	2.3	4.4	4.1
Interest, dividends [3]	35.8	32.8	32.2	48.4	60.4	74.8	85.5	95.3	32.9	79.6	72.2
Food stamps	11.1	24.1	24.5	10.2	2.1	0.7	0.4	0.1	22.4	1.7	5.0
Housing assistance	14.9	19.2	21.1	16.5	12.4	7.2	2.4	0.5	19.7	5.5	7.7
CHARACTERISTICS OF PERSONS											
Number of people (thousands)	455	603	1,752	1,919	2,008	3,135	4,526	7,421	2,810	19,010	21,820
Percent white non-Hispanic [4]	80.4	72.3	73.0	83.8	91.5	91.0	94.1	96.4	74.1	93.2	90.7
Percent black non-Hispanic	16.4	23.8	21.0	11.8	5.6	6.7	4.1	2.1	20.9	4.7	6.8
Percent Hispanic	3.3	3.9	5.9	4.4	2.8	2.4	1.7	1.5	5.1	2.1	2.5
Percent unrelated individuals	67.4	82.9	77.6	69.3	59.4	45.1	38.2	26.9	77.1	40.3	45.0
Percent female	68.2	78.8	75.5	70.7	70.1	63.7	59.8	56.1	75.1	61.2	63.0
Percent age 75 and over	56.4	57.4	57.9	53.8	51.5	48.5	41.5	33.0	57.6	41.6	43.7
Percent female and age 75 and over	40.8	44.1	45.8	39.3	36.5	30.3	23.0	17.3	44.6	25.1	27.6

---

[1] Includes unrelated individuals (elderly living alone). [2] Based on census ("Orshansky") poverty levels.
[3] Negative incomes (i.e., losses) set to zero. [4] Includes other races.

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 10.—PERCENT OF TOTAL UNIT INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] FOR UNITS WITH ALL MEMBERS AGE 65 OR OVER, 1989

	Ratio of total income to poverty threshold—poverty ratio										
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	Poor	Nonpoor	Total
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Earnings [2]	1.2	1.6	0.9	1.4	2.7	3.5	6.0	17.1	1.1	12.6	12.1
OASDI, railroad retirement	61.4	68.7	73.3	78.8	76.3	69.1	54.8	24.6	71.6	38.7	40.1
Pensions	4.3	2.4	3.1	2.9	5.9	10.5	17.9	20.4	3.0	17.6	17.0
Unemployment compensation, workers compensation, veterans payments	1.1	1.2	1.0	2.7	0.7	1.5	1.1	0.7	1.1	0.9	0.9
AFDC, SSI, general assistance	3.7	9.7	9.7	3.5	3.1	1.2	0.2	0.0	9.3	0.4	0.8
Child support, alimony	1.0	0.2	0.4	0.7	0.8	0.9	0.9	0.8	0.4	0.8	0.8
Interest, dividends [2]	10.2	5.4	3.0	5.4	8.2	12.6	19.0	36.4	3.9	28.5	27.5
Food stamps [3]	3.4	3.1	1.8	0.5	0.1	0.0	0.0	0.0	2.1	0.0	0.1
Housing assistance [3]	13.8	7.6	6.8	4.0	2.2	0.7	0.1	0.0	7.4	0.4	0.7
Mean cash income per family member [4]	$1,499	$4,131	$5,215	$6,202	$7,096	$8,290	$11,297	$25,146	$4,380	$15,250	$13,850
Mean family size	1.2	1.1	1.1	1.2	1.3	1.4	1.4	1.6	1.1	1.4	1.4

[1] Based on census ("Orshansky") poverty levels.

[2] Negative incomes (i.e., losses) set to zero.

[3] The cash value of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

[4] Includes cash values of food stamps and housing assistance. Incomes not adjusted for losses.

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 11.—PERCENT OF MARRIED COUPLES WITH ALL MEMBERS AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES, AND PERCENT OF TOTAL FAMILY INCOME FROM EACH SOURCE, BY POVERTY[1] STATUS: 1989

	Percent of couples with income from each source			Percent of total income from each source		
	Total	Poor	Non-poor	Total	Poor	Non-poor
Number of married couples (in thousands)	5,607	306	5,301	NA	NA	NA
Percent of married couples	100.0	5.5	94.5	NA	NA	NA
Earnings [2]	23.4	7.7	24.3	13.9	1.1	14.1
OASDI, railroad retirement	97.4	92.5	97.6	37.8	78.4	37.4
Pensions	56.7	9.4	59.5	18.5	3.3	18.7
Veterans, UC, and other compensation	7.3	6.3	7.4	0.7	1.5	0.7
AFDC, SSI, general assistance	2.6	16.4	1.8	0.3	4.8	0.2
Child support, alimony	4.1	2.4	4.2	0.7	0.3	0.7
Interest, dividends [2]	82.1	43.8	84.3	27.9	7.7	28.2
Food stamps [3]	1.6	14.4	0.9	0.0	1.4	0.0
Housing assistance [3]	1.8	4.8	1.6	0.1	1.5	0.1

[1] Based on Orshansky poverty levels. [2] Negative incomes (i.e., losses) set to zero.

[3] The cash value of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

NA—Not applicable.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 12.—PERCENT OF UNRELATED INDIVIDUALS[1] AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES AND PERCENT OF TOTAL INCOME FROM EACH SOURCE, BY POVERTY STATUS:[2] 1989

	Percent of units with income from each source			Percent of total income from each source		
	Total	Poor	Non-poor	Total	Poor	Non-poor
Number of individuals (in thousands)	9,828	2,166	7,663	NA	NA	NA
Percent of individuals	100.0	22.0	78.0	NA	NA	NA
Earnings[3]	13.4	4.2	16.0	9.9	1.1	10.6
OASDI, Railroad retirement	93.4	88.2	94.9	42.6	70.6	40.2
Pensions	34.7	7.7	42.3	15.3	3.0	16.3
Veterans, UC, and other compensation	4.9	3.8	5.2	1.2	1.0	1.2
AFDC, SSI, general assistance	8.8	27.2	3.6	1.4	9.9	0.6
Child support, alimony	4.1	2.3	4.7	1.0	0.5	1.0
Interest, dividends[3]	66.5	31.5	76.4	27.2	3.3	29.2
Food stamps[4]	6.9	23.4	2.2	0.2	2.2	0.0
Housing assistance[4]	11.2	21.9	8.2	1.4	8.4	0.8

[1] Elderly living alone. [2] Based on Orshansky poverty levels. [3] Negative incomes (i.e., losses) set to zero.

[4] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

NA—Not applicable.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 13.—TRENDS IN DEMOGRAPHIC CHARACTERISTICS AND INCOME COMPOSITION OF ELDERLY UNITS[1] WITH ALL MEMBERS AGE 65 OR OVER, BY POVERTY STATUS[2]

	Poor		Nonpoor		Total	
	1979	1989	1979	1989	1979	1989
Number of units (in thousands)	2,619	2,483	9,786	13,262	12,405	15,745
Number of persons (in thousands)	3,002	2,810	14,301	19,010	17,303	21,820
Characteristics of persons:						
Percent white non-Hispanic[3]	79.5	74.1	94.0	93.2	91.5	90.7
Percent black non-Hispanic	16.8	20.9	4.7	4.7	6.8	6.8
Percent Hispanic	3.6	5.1	1.3	2.1	1.7	2.5
Percent female	73.9	75.1	61.4	61.2	63.6	63.0
Percent age 75 and over	48.7	57.6	37.5	41.6	39.4	43.7
Percent female age 75 and over	36.1	44.6	21.8	25.1	24.3	27.6
Percent unrelated individuals	74.7	77.1	37.8	40.3	44.2	45.0
Average family size	1.1	1.1	1.5	1.4	1.4	1.4
Percent with income from various sources:						
Earnings[4]	5.8	4.6	22.9	19.4	19.2	17.1
OASDI, railroad retirement	86.0	88.7	94.8	96.0	92.9	94.9
Pensions	5.2	7.9	40.5	49.4	33.0	42.8
Unemployment compensation, workers compensation, veterans payments	5.7	4.1	7.5	6.2	7.1	5.9
AFDC, SSI, general assistance	28.4	26.0	5.1	3.2	10.0	6.8
Child support, alimony	1.8	2.3	2.5	4.4	2.3	4.1
Interest, dividends[4]	37.6	32.9	81.5	79.6	72.2	72.2
Food stamps	20.6	22.4	1.8	1.7	5.8	5.0
Housing assistance	11.9	19.7	4.6	5.5	6.1	7.7
Percent of total income from:						
Earnings[4]	1.3	1.1	14.5	12.6	13.7	12.1
OASDI, railroad retirement	71.3	71.6	41.5	38.7	43.5	40.1
Pensions	1.8	3.0	15.0	17.6	14.1	17.0
Unemployment compensation, workers compensation, veterans payments	2.1	1.1	1.4	0.9	1.4	0.9
AFDC, SSI, general assistance	11.0	9.3	0.8	0.4	1.5	0.8
Child support, alimony	0.4	0.4	0.5	0.8	0.5	0.8
Interest, dividends[4]	4.2	3.9	25.5	28.5	24.0	27.5
Food stamps[5]	2.4	2.1	0.0	0.0	0.2	0.1
Housing assistance[5]	5.4	7.4	0.8	0.4	1.1	0.7
Mean income per family member[6]	$4,160	$4,380	$12,334	$15,250	$10,916	$13,850

---

[1] Includes unrelated individuals (elderly living alone). [2] Based on census ("Orshansky") poverty levels. [3] Includes "other races." [4] Negative incomes (i.e., losses) set to zero. [5] The cash value of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income. [6] Includes cash value of food stamps and housing assistance and includes negative incomes (i.e., losses); 1979 dollars converted to 1989 dollars by use of the CPI–X1 price index.

Note: Details may not sum to totals due to rounding.

Source: March 1980, 1990 Current Population Surveys (CPS). Table prepared by CRS.

TABLE 14.—PERCENT OF UNITS [1] WITH ALL MEMBERS AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES, AND PERCENT OF TOTAL UNIT INCOME FROM VARIOUS SOURCES, BY FAMILY INCOME,[2] 1989

	Total family income						
	Under $10,000	$10,000 to $19,999	$20,000 to $29,999	$30,000 to $49,999	$50,000 to $74,999	$75,000 and over	Total
Number of units (in thousands)	5,994	4,984	2,284	1,600	521	363	15,745
Number of persons (in thousands)	6,715	7,134	3,722	2,676	909	665	21,820
Family Characteristics:							
Percent white non-Hispanic [3]	82.0	92.9	94.6	97.0	98.8	98.0	90.7
Percent black non-Hispanic	14.0	5.0	3.2	2.0	0.6	0.8	6.8
Percent Hispanic	4.0	2.1	2.2	1.1	0.6	1.2	2.5
Percent female	74.5	61.1	56.4	54.2	52.5	52.5	63.0
Percent age 75 and over	55.6	44.0	36.7	31.5	28.6	28.4	43.7
Percent female age 75 and over	42.6	25.7	18.9	15.5	13.8	13.0	27.6
Percent unrelated individual	78.7	40.4	23.7	21.0	16.5	10.2	45.0
Average family size	1.1	1.4	1.6	1.7	1.7	1.8	1.4
Percent with income from:							
Earnings [4]	6.4	15.8	24.3	34.6	39.0	57.9	17.1
OASDI, railroad retirement	93.4	97.0	95.9	94.8	92.9	87.7	94.9
Pensions	16.5	51.1	66.6	70.0	67.5	59.3	42.8
Unemployment compensation, workers compensations, veterans payments	4.9	5.7	6.8	8.1	6.9	6.2	5.9
AFDC, SSI, general assistance	15.6	2.1	0.4	0.7	0.3	0.5	6.8
Child support, alimony	3.1	4.8	5.0	3.7	6.4	5.9	4.1
Interest, dividends [4]	47.3	80.6	92.5	96.8	96.6	97.6	72.2
Food stamps [5]	12.4	0.7	0.1	0.2	0.0	0.0	5.0
Housing assistance [5]	16.5	4.1	0.7	0.4	0.0	0.0	7.7

TABLE 14.—PERCENT OF UNITS [1] WITH ALL MEMBERS AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES, AND PERCENT OF TOTAL UNIT INCOME FROM VARIOUS SOURCES, BY FAMILY INCOME,[2] 1989—Continued

	Total family income						
	Under $10,000	$10,000 to $19,999	$20,000 to $29,999	$30,000 to $49,999	$50,000 to $74,999	$75,000 and over	Total
Percent of total income from:							
Earnings [4]	2.0	5.8	9.4	15.1	18.8	27.4	12.1
OASDI, railroad retirement	73.9	58.2	40.9	27.1	17.5	9.9	40.1
Pensions	4.6	15.5	21.1	23.4	20.6	14.4	17.0
Unemployment compensation, workers compensation, veterans payments	1.4	1.2	1.1	0.9	0.3	0.3	0.9
AFDC, SSI, general assistance	5.0	0.5	0.0	0.0	0.0	0.0	0.8
Child support, alimony	0.8	1.0	0.8	0.5	0.7	0.9	0.8
Interest, dividends [4]	7.0	17.6	26.6	33.0	42.1	47.2	27.5
Food stamps [5]	0.8	0.0	0.0	0.0	0.0	0.0	0.1
Housing assistance [5]	4.4	0.2	0.0	0.0	0.0	0.0	0.7
Mean income per family member [6]	$6,095	$10,062	$15,045	$22,612	$34,711	$62,372	$13,850

[1] Included unrelated individuals (elderly living alone).

[2] Family income excludes cash values of food stamps and public housing, and makes no adjustment for negative incomes.

[3] Includes "other races."

[4] Negative incomes (i.e., losses) set to zero.

[5] The cash value of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

[6] Includes cash value of food stamps and housing assistance. Incomes not adjusted for losses.

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 15.—COMPARISON OF ELDERLY UNITS [1] WITH ALL MEMBERS AGE 65 TO 79 TO ALL MEMBERS 80 AND OVER, 1989

Age	Poor		Nonpoor		Total	
	65–79	80+	65–79	80+	65–79	80+
Number of units (in thousands)	1,615	868	10,188	3,073	11,803	3,942
Number of persons (in thousands)	1,882	928	15,221	3,789	17,102	4,717
Characteristics of persons:						
Percent white non-Hispanic [2]	72.5	77.1	93.0	93.9	90.8	90.6
Percent black non-Hispanic	21.9	18.8	4.7	4.6	6.6	7.4
Percent Hispanic	5.6	4.0	2.3	1.5	2.6	2.0
Percent female	73.3	78.7	61.0	61.9	62.4	65.2
Percent unrelated individuals	73.5	84.3	36.4	55.9	40.5	61.5
Average family size	1.1	1.1	1.5	1.3	1.4	1.3
Percent with income from:						
Earnings [3]	5.8	2.5	23.2	6.9	20.8	5.9
OASDI, railroad retirement	88.0	90.1	95.6	97.6	94.5	95.9
Pensions	6.9	9.8	51.6	42.1	45.5	35.0
UC and other compensation	4.6	3.1	7.1	3.2	6.7	3.2
AFDC, SSI, general assistance	26.9	24.3	2.9	4.0	6.2	8.5
Child support, alimony	2.2	2.5	4.5	4.1	4.2	3.7
Interest, dividends [3]	30.6	37.1	79.3	80.6	72.6	71.0
Food stamps [4]	24.8	17.9	1.9	1.3	5.0	4.9
Housing assistance [4]	20.2	18.8	5.2	6.4	7.2	9.2
Percent of total income from:						
Earnings [3]	1.5	0.3	14.7	3.5	14.3	3.2
OASDI, railroad retirement	71.2	72.3	37.3	44.7	38.4	46.7
Pensions	2.6	3.7	18.4	14.3	17.8	13.5
UC and other compensation	1.1	1.0	1.0	0.7	1.0	0.7
AFDC, SSI, general assistance	9.8	8.5	0.4	0.7	0.7	1.2
Child support, alimony	0.4	0.5	0.8	1.0	0.8	1.0
Interest, dividends [3]	3.7	4.5	27.1	34.6	26.3	32.4
Food stamps [4]	2.2	2.1	0.0	0.0	0.1	0.2
Housing assistance [4]	7.5	7.2	0.3	0.5	0.6	1.0
Mean income per family member [5]	$4,308	$4,527	$15,677	$13,533	$14,426	$11,761

---

[1] Includes unrelated individuals (elderly living alone).

[2] Includes "other" races.

[3] Negative incomes (i.e., losses) set to zero.

[4] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.
[5] Includes cash values of food stamps and housing assistance, and includes negative incomes (i.e., losses).

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 16.—PERCENT OF UNITS [1] WITH ANY MEMBER AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES, AND PERCENT OF TOTAL UNIT INCOME FROM EACH SOURCE, BY POVERTY [2] STATUS: 1989

	Percent of units with income from each source			Percent of unit income from each source		
	Total	Poor	Nonpoor	Total	Poor	Nonpoor
Number of units (in thousands)	22,350	2,988	19,362	NA	NA	NA
Number of aged individuals (in thousands)	29,566	3,369	26,197	NA	NA	NA
Percent of units	100.0	13.4	86.6	NA	NA	NA
Earnings [3]	33.7	10.1	37.4	30.9	4.3	31.7
OASDI, railroad retirement	93.0	88.2	93.7	30.2	67.4	29.1
Pensions	42.9	8.2	48.3	14.1	2.8	14.4
Unemployment compensation, workers compensation, veterans payments	8.0	4.4	8.6	1.1	1.1	1.1
AFDC, SSI, general assistance	8.4	28.5	5.3	1.0	10.9	0.7
Child support, alimony	5.6	3.1	6.0	0.9	0.6	0.9
Interest, dividends [3]	72.0	31.9	78.2	21.3	3.5	21.8
Food stamps [4]	5.2	24.5	2.2	0.1	3.1	0.0
Housing assistance [4]	6.0	17.9	4.1	0.4	6.2	0.2

[1] Includes both families and unrelated individuals.
[2] Based on census ("Orshansky") poverty levels.
[3] Negative income (i.e., losses) set to zero.
[4] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.
NA—Not applicable.

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 17.—PERCENTAGE DISTRIBUTION OF SELECTED SOURCES OF INCOME RECEIVED BY UNITS WITH AN AGED MEMBER [1] BY FAMILY MONEY INCOME AS A RATIO OF THE POVERTY LEVEL,[2] 1989

[In percent]

Type of income	Percent received by units with aged individuals	Ratio of total income to poverty threshold										
		Total	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	Poor	Nonpoor
Total income [3]	16.4	100.0	0.2	0.6	1.9	2.7	3.4	6.7	14.8	69.8	2.6	97.4
Social security and railroad retirement	83.6	100.0	0.5	1.4	4.7	6.7	7.8	13.7	22.6	42.7	6.6	93.4
SSI	43.6	100.0	1.2	8.7	23.6	14.4	15.6	14.8	10.4	11.3	33.5	66.5
AFDC and general assistance	4.8	100.0	5.3	8.2	16.5	11.7	18.9	13.3	10.8	15.1	30.1	69.9
Food stamps [4]	8.7	100.0	12.9	21.2	33.9	15.6	6.2	5.4	3.2	1.7	68.0	32.0
Unemployment compensation, workers compensation, and veterans payments	19.0	100.0	0.2	0.6	2.1	6.7	4.2	9.5	18.7	57.9	3.0	97.0
Wages, salaries, farm and self-employment	6.4	100.0	0.0	0.1	0.3	0.5	1.1	2.7	9.5	85.7	0.4	99.6
Pensions	58.6	100.0	0.1	0.1	0.4	0.7	1.4	4.8	16.5	76.0	0.6	99.4
Child support, alimony	10.8	100.0	0.4	0.4	1.2	2.8	3.6	7.2	16.5	67.9	2.0	98.0
Interest, dividends [5]	46.9	100.0	0.1	0.1	0.3	0.6	1.1	3.2	10.1	84.4	0.5	99.5

[1] Includes families with an aged member and aged unrelated individuals living alone.

[2] Based on census ("Orshansky") poverty levels.

[3] Total income excludes cash values of food stamps and public housing and includes losses.

[4] The cash values of food stamps were estimated using their market values.

[5] Negative incomes (i.e., losses) set to zero.

Note: This table shows for families with at least one aged member the percentage of selected sources of income received by families classified by poverty level. The first number in the first column, 16.4 percent, means that 16.4 percent of all income accrues to families that include an aged member. The third number in the first row means 0.2 percent of all income received by these families accrues to those families that have an income of less than 50 percent of the poverty level. Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

Tables 18 through 20 provide data from the Current Population Survey for 1990. Table 18 shows the distribution of the share of total family income that is accounted for by Social Security income. The tables include all units where the head is age 65 and over, including families and unrelated individuals. For example, for elderly units in poverty, Social Security represents over 90 percent of their income in 48.3 percent of such families. In less than 1 percent of elderly families with income three times the poverty level does Social Security income constitute more than 90 percent of total family income.

Table 19 presents similar information except that it shows the percent of family income derived from supplemental security income (SSI) and Social Security benefits combined.

Table 20 presents the number of families with an aged head with different combinations of SSI, Social Security or railroad retirement, and food stamp income. For families in poverty, 88.6 percent receive Social Security or railroad retirement, 26.3 percent receive SSI, and 24.0 percent receive food stamp benefits. Only 11.8 percent of elderly families under poverty receive all three types of income.

TABLE 18.—SOCIAL SECURITY INCOME AS A PERCENT OF TOTAL UNIT INCOME, BY RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] FOR UNITS WITH A HEAD AGE 65 OR OVER, 1989

[In percent]

	Ratio of total income to poverty threshold									Poor	Nonpoor
	Total	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over		
Number of units (thousands)	20,562	468	680	1,721	1,869	1,855	2,764	4,082	7,123	2,869	17,693
Number of individuals aged 65 and over (thousands)	27,420	547	733	1,954	2,209	2,316	3,710	5,643	10,309	3,234	24,186
Total (percent of units)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Social Security as a percent of total income: [2]											
0.1 to 24.9	18.1	3.0	2.0	1.3	1.8	2.4	4.4	9.6	43.2	1.7	20.8
25 to 49.9	24.5	8.1	7.2	5.7	7.4	9.4	15.7	32.6	38.8	6.5	27.4
50 to 79.9	25.7	8.9	23.0	22.9	22.3	32.3	43.3	45.6	8.7	20.7	26.5
80 to 89.9	7.1	6.7	9.2	12.6	13.6	15.0	14.2	4.6	0.4	10.8	6.4
90 or more	18.3	[4] 38.6	48.5	50.8	51.4	37.6	19.1	4.2	0.3	48.3	13.4
Percent of units with Social Security income [3]	93.7	69.1	89.9	93.3	96.5	96.7	96.8	96.6	91.4	88.6	94.5
Percent of units without Social Security income	6.3	30.9	10.1	6.7	3.5	3.3	3.2	3.4	8.6	11.4	5.5

---

[1] Based on Census ("Orshansky") poverty levels.

[2] Total income excludes the cash values of food stamps and public housing assistance.

[3] Total percent of units receiving Social Security income may be greater than the sum of percents of units broken down by Social Security income as a percent of total income because the total percent includes units with negative total income who receive Social Security.

[4] The number 38.6 in the second column means that 38.6 percent of units with a head age 65 or over with total incomes less than 50 percent of poverty depend upon Social Security benefits for 90 percent or more of their income.

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 19.—SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME AS A PERCENT OF TOTAL UNIT INCOME, BY RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] FOR UNITS WITH A HEAD AGE 65 OR OVER, 1989

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Social Security and SSI as a percent of total income: [2]											
0.1 to 24.9	3.0	1.2	1.8	1.2	2.0	4.0	9.4	43.2	1.8	20.5	17.9
25 to 49.9	6.4	5.6	3.5	6.0	8.8	15.5	32.0	39.0	4.5	27.1	23.9
50 to 79.9	8.0	14.3	11.5	19.3	29.1	43.3	46.1	8.8	11.6	26.0	24.0
80 to 89.9	4.9	7.7	9.7	12.1	14.8	14.3	4.6	0.4	8.5	6.3	6.6
90 or more	[4] 46.6	69.0	71.8	59.3	43.9	20.8	4.5	0.3	67.0	15.3	22.5
Percent of units with Social Security and/or SSI income [3]	72.7	97.8	98.4	98.0	98.5	97.8	96.6	91.6	94.0	95.1	95.0
Percent of units without Social Security or SSI income	27.3	2.2	1.6	2.0	1.5	2.2	3.4	8.4	6.0	4.9	5.0

---

[1] Based on census ("Orshansky") poverty levels.

[2] Total income excludes the cash values of food stamps and public housing assistance.

[3] Total percent of units receiving Social Security and or SSI benefits may be greater than the sum of percents of units broken down by Social Security and SSI income as a percent of total income because the total percent includes units with negative total income who receive Social Security and/or SSI benefits.

[4] The number 46.6 in the second column means that 46.6 percent of families with a head over age 65 with total incomes less than 50 percent of poverty depend upon Social Security and/or SSI benefits for 90 percent or more of their income.

Note: Details may not sum to totals due to rounding.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

TABLE 20.—RECEIPT OF SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, FOOD STAMPS, AND COMBINATIONS THEREOF, AMONG UNITS[1] WITH AN AGED HEAD CLASSIFIED BY FAMILY MONEY INCOME AS A PERCENT OF THE POVERTY THRESHOLD: 1989

Type of benefit	Less than 100 percent of poverty threshold		100 to 149.9 percent of poverty threshold	
	Number (in thousands)	Percent	Number (in thousands)	Percent
Social Security [2]	2,541	88.6	3,597	96.6
SSI	755	26.3	395	10.6
Food stamps	687	24.0	264	7.1
Social Security only [3]	1,694	59.1	3,119	83.7
SSI only [3]	74	2.6	42	1.1
Food stamps only [3]	18	0.6	12	0.3
Social Security and food stamps [4]	248	8.6	144	3.9
Social Security and SSI [4]	259	9.0	245	6.6
SSI and food stamps [4]	82	2.9	19	0.5
All three income sources	339	11.8	89	2.4
No Social Security, SSI, or food stamps	154	5.4	54	1.5
Total	2,869	....	3,724	....

[1] Includes unrelated individuals and elderly individuals living alone.

[2] Includes railroad retirement.

[3] Row 4 which is labeled "social security only" means the family only receives social security and does not receive SSI or food stamps. The family could be receiving other types of income. The same is true of rows 5 and 6.

[4] Family receives only the two types of income specified but not the third. The family could be receiving other sources of income than the three mentioned.

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

HOUSING ARRANGEMENTS OF THE ELDERLY

Table 21 shows housing tenure for poor and nonpoor aged families and unrelated individuals. The table shows that the majority of poor families with an aged member (69 percent) and aged poor unrelated individuals (51 percent) owned their own home or lived with relatives in an owner occupied unit. In comparison, 87 percent of aged nonpoor families and 66 percent of aged nonpoor unrelated individuals owned their own home. Almost one in four (22.8 percent) poor aged unrelated individuals reported living in publicly supported housing (either public housing or rent subsidized housing). About 9 percent of aged nonpoor unrelated individuals lived in publicly supported housing.

TABLE 21.—HOUSING TENURE OF AGED FAMILIES AND UNRELATED INDIVIDUALS BY FAMILY TYPE AND POVERTY STATUS, 1989

	Total (in thousands)	Percent of total				
		Own housing	No cash rent	Rent housing		
				Total	Publicly supported	Not publicly supported
Any member age 65 or over:						
In families:						
Total	12,521	85.7	1.0	13.3	1.9	11.4
Poor	822	69.0	2.8	28.2	7.4	20.7
Nonpoor	11,699	86.8	0.9	12.3	1.6	10.7
Unrelated individuals:						
Total	9,828	62.4	3.5	34.1	11.8	22.3
Poor	2,166	50.6	5.5	43.9	22.8	21.1
Nonpoor	7,663	65.8	2.9	31.3	8.7	22.6

Source: March 1990 Current Population Survey (CPS). Table prepared by CRS.

PRESENT VALUES OF SOCIAL SECURITY AND MEDICARE TAXES AND BENEFITS

Many people are interested in comparing the value of Social Security and Medicare benefits to the amount of the payroll taxes and premiums paid to acquire those benefits. However, it must first be understood that the Social Security and Medicare programs are social insurance programs, and they have both social and insurance goals. As with other types of insurance, benefits are paid upon the occurrence of an event such as illness, death, disability, or retirement. Also, benefits are provided without regard to total premium payments so long as basic qualifying conditions have been met regarding insured status. As *social* insurance, Social Security and Medicare are structured to meet social goals, or, in other words, to provide socially adequate benefits. For example, Social Security replaces a higher proportion of the previous earnings of a low-income worker than a high-income worker. It also provides an array of dependents' benefits at no cost for workers with families beyond that paid by workers without dependents.

While this section discusses several ways of comparing benefits to contributions, it should be noted that such comparisons are not suitable for a social insurance program. The worth of social insurance programs cannot be fully assessed on the basis of the individual return on one's contribution because such an analysis does not adequately reflect the social benefits of these programs. Social benefits of the Social Security and Medicare programs include giving a measure of economic independence to the elderly and providing for orphaned children, surviving spouses, and those unable to work due to disability. In addition, younger workers are in large part relieved from the financial burden of supporting their parents, and the elderly are afforded an opportunity to live independently and with dignity.

A comparison of taxes paid to benefits received involves many judgments and caveats and is subject to considerable limitations. The exact relationship of Social Security and Medicare benefits to total taxes and premiums paid is not predictable for each and every worker. For example, some workers may collect Social Security and Medicare benefits for many years after retirement and receive benefits which are many times the value of their taxes and premiums. Other workers, who die before or shortly after retirement and leave no survivors, may collect only a few dollars in benefits or perhaps none at all.

There are several other considerations. First, there really is no "typical" beneficiary with a "typical" work history. The "average" benefit for all workers is the result of millions of different work histories. Second, payroll taxes do not provide retirement benefits only. They also provide benefits for disabled workers and for dependents of retired, disabled, and deceased workers, as well as hospital insurance protection to those over age 65 and the disabled. In fact, only about half of the payroll tax is used to pay cash retirement benefits.

The total amount of benefits paid also depends upon each worker's individual circumstances—whether he or she was a high earner or a low earner, whether he or she is married or has children who are eligible to collect benefits, and how long the worker and his or her dependents collect benefits. Because of the weighted Social Security benefit formula, Social Security benefits are higher in relation to earnings and contributions for a low-wage worker than a high-wage worker. Furthermore, some higher-income retirees have to pay Federal income taxes on up to one-half of their Social Security benefits. Although the Social Security benefit is still paid in full, many people regard benefits taxation as a reduction in benefits.

These variable factors make comparisons problemmatic and make it virtually impossible to construct an example for a typical and representative worker. However, comparing examples for a range of retirement situations can be informative. Although about three-fourths of workers begin collecting benefits at age 62 and half of beneficiaries coming on the rolls each year are dependents of retired, disabled or deceased workers, for simplicity this analysis uses the following assumptions about hypothetical workers. It assumes that each such worker retired at age 65 in January 1991 after having worked full time in employment covered by Social Security beginning at age 21 (i.e., in 1947). Similarly, all the illustrations reflect three lifetime earnings patterns—workers who always earned either (1) the Federal minimum wage, (2) the average wage in the economy, or (3) the maximum wage subject to Social Security (OASDI) tax. Finally, these illustrations do not take into account the value of additional benefits that may be payable to family members either while the worker is living or after he or she has died, leaving survivors. To offset this, taxes only include HI and the retirement portion of payroll taxes. Taxes do not include the disability and survivor portions of the tax.

The methodology used compares the present value of Social Security and Medicare benefits to the present value of the payroll taxes paid by these workers. In this context, the present value of taxes is all payroll taxes contributed plus the interest that would have accumulated by the time of retirement. The present value of benefits is equal to the amount that would have to be invested at the time of retirement to be sufficient to pay for the benefits projected to be received over the person's expected lifetime. Thus, both past taxes and future benefits are discounted by the actual or assumed interest rate prevailing in each year. The present values for benefits are differentiated by sex because males and females have different life expectancies (males and females reaching age 65 in 1991 have an average life expectancy of 15.1 and 18.9 years, respectively). The calculations do not reflect any income-tax consequences of interest earned (i.e., interest is assumed to be tax-free). Present values are displayed four ways: in dollars, both the present value of benefits and taxes and the difference between the two (the net present value); in a ratio of benefits to taxes; and in "payback" times. The payback time is the amount of time it takes for a retiree to recover through benefit payments everything he or she paid in payroll taxes plus interest, assuming cost-of-living increases and the continued accrual of interest.

The assumptions used regarding projected interest rates, cost-of-living adjustments to benefits, Medicare costs, and life expectancies are those contained in the Alternative II–B projections of the 1990 Report of the Social Security Board of Trustees. Past interest rates are those earned by the Social Security trust funds in U.S. Government investments.

Present value analysis is very sensitive to interest rates. For example, were the value of taxes paid invested wisely (or luckily), its value may multiply by many times. On the other hand, it is possible that the entire amount could be virtually wiped out by poor investment choices or by a severe and untimely downturn in the stockmarket. A general principle of economics is that the greater the degree of risk, the higher the interest rate. To obtain a middle ground, reflecting reasonable and safe investment practices, it is assumed that Social Security contributions were always placed in U.S. Government obligations. Social Security taxes not immediately needed to pay benefits have always been invested in U.S. Government securities, so to provide illustrations, this analysis uses the effective interest rate earned, or projected to be earned, by the Social Security trust funds over the years. The sensitivity analysis at the conclusion of this section illustrates the sensitivity of these projections to changes in the assumptions used.

In computing the accumulated value of Social Security taxes, the amount of payroll tax used is that portion of the Old-Age and Survivors Insurance (OASI) tax that may be judged solely attributable to the payment of retirement benefits. Using the entire OASI tax would be incorrect because it funds both retirement and survivors benefits, and the benefit analysis in this discussion considers only retirement benefits. Unlike Disability Insurance (DI) and Hospital Insurance (HI) taxes, however, Old-Age Insurance and Survivors Insurance taxes are not separately allocated in the law. To obtain the proportion of the OASI tax attributable to retirement benefits, it is assumed that if such tax rates were specified they would be in the same proportion to OASI tax rates as retirement benefits are to all benefits funded by the OASI trust fund for each year. On average, about 75 percent of OASI benefits have been retirement benefits. The retirement tax rate and the cumulative amount of retirement taxes, plus interest, for the three earnings levels is shown in table 22.

TABLE 22.— CUMULATIVE RETIREMENT PORTION OF SOCIAL SECURITY TAXES PLUS INTEREST, 1947–90

Year	Tax rate (percent) [1]	Interest rate (percent) [2]	Earnings [3]			Cumulative taxes plus interest		
			Minimum earner	Average earner	Maximum earner	Minimum earner	Average earner	Maximum earner
1947..	0.62	1.884	$832	$2,175	$3,000	$5	$14	$19
1948..	.63	2.832	832	2,362	3,000	11	29	39
1949..	.66	1.299	832	2,483	3,000	16	46	59
1950..	1.02	2.018	1,499	2,544	3,000	32	73	91
1951..	1.05	2.888	1,560	2,799	3,600	50	105	132
1952..	1.05	2.240	1,560	2,973	3,600	67	139	173
1953..	1.09	2.310	1,560	3,139	3,600	86	177	217
1954..	1.47	2.296	1,560	3,156	3,600	111	227	275
1955..	1.51	2.198	1,560	3,301	4,200	137	283	345
1956..	1.53	2.401	1,993	3,532	4,200	171	344	418
1957..	1.55	2.492	2,080	3,642	4,200	208	410	495
1958..	1.55	2.516	2,080	3,674	4,200	246	478	573
1959..	1.74	2.578	2,080	3,856	4,800	289	558	672
1960..	2.11	2.598	2,080	4,007	4,800	341	658	793
1961..	2.09	2.755	2,184	4,087	4,800	397	763	916
1962..	2.19	2.825	2,392	4,291	4,800	461	880	1,049
1963..	2.56	2.923	2,461	4,397	4,800	539	1,020	1,204
1964..	2.55	3.084	2,600	4,576	4,800	623	1,170	1,366
1965..	2.53	3.184	2,600	4,659	4,800	709	1,327	1,532
1966..	2.57	3.483	2,600	4,938	6,600	802	1,502	1,758
1967..	2.60	3.753	2,886	5,213	6,600	909	1,697	1,999
1968..	2.41	3.950	3,293	5,572	7,800	1,026	1,901	2,270
1969..	2.71	4.437	3,328	5,894	7,800	1,163	2,149	2,587
1970..	2.66	5.074	3,328	6,186	7,800	1,313	2,427	2,931
1971..	2.96	5.286	3,328	6,497	7,800	1,484	2,752	3,323
1972..	2.97	5.406	3,328	7,134	9,000	1,666	3,119	3,778
1973..	3.10	5.754	3,328	7,580	10,800	1,868	3,540	4,339
1974..	3.17	6.218	3,883	8,031	13,200	2,111	4,023	5,040
1975..	3.18	6.593	4,368	8,631	14,100	2,393	4,572	5,836
1976..	3.20	6.731	4,784	9,226	15,300	2,713	5,185	6,735
1977..	3.21	6.958	4,784	9,779	16,500	3,060	5,870	7,752
1978..	3.15	7.199	5,512	10,556	17,700	3,461	6,638	8,888
1979..	3.21	7.524	6,032	11,479	22,900	3,922	7,519	10,318
1980..	3.36	8.568	6,448	12,513	25,900	4,483	8,601	12,108
1981..	3.51	9.947	6,968	13,773	29,700	5,186	9,964	14,408
1982..	3.46	11.178	6,968	14,531	32,400	6,020	11,608	17,201
1983..	3.64	10.768	6,968	15,239	35,700	6,936	13,443	20,424

TABLE 22.— CUMULATIVE RETIREMENT PORTION OF SOCIAL SECURITY TAXES PLUS INTEREST, 1947-90—Continued

Year	Tax rate (percent) [1]	Interest rate (percent) [2]	Earnings [3]			Cumulative taxes plus interest		
			Minimum earner	Average earner	Maximum earner	Minimum earner	Average earner	Maximum earner
1984..	3.78	11.601	6,968	16,135	37,800	8,019	15,647	24,302
1985..	3.99	11.213	6,968	16,823	39,600	9,211	18,110	28,696
1986..	4.00	11.091	6,968	17,322	42,000	10,527	20,849	33,649
1987..	4.00	10.063	6,968	18,427	43,800	11,879	23,721	38,875
1988..	4.26	9.773	6,968	19,334	45,000	13,351	26,902	44,682
1989..	4.26	9.555	6,968	20,100	48,000	14,937	30,370	51,095
1990..	4.35	9.248	7,670	21,179	51,300	16,668	34,142	58,154

[1] Old-age taxes were derived by applying the ratio of Old-Age benefits/total OASI benefits to the OASI tax rates.

[2] Interest rates for 1947-90 are from data developed by the Office of the Actuary of SSA.

[3] This table uses the average wage series for indexing earnings, for the period 1951 through 1989, developed by SSA in computing benefit amounts. The average wage for 1990 is based on updated II-B Intermediate assumptions in the Report of the Social Security Board of Trustees. For the period 1947 through 1950, the average wage figures were extrapolated by the Office of the Actuary from the Social Security wage series using Social Security taxable wage data.

Source: Congressional Research Service.

Workers retiring in 1991 at age 65 who always earned either the minimum, average, or maximum wage creditable under Social Security receive a monthly benefit of $491, $751 and $1,022, respectively. As table 26 shows, the present value of benefits substantially exceeds the present value of taxes paid. The *net* present value shows the difference between benefits and taxes.

Many would say that the employer's share of the payroll tax should be included, because it also goes to fund these programs. However, there is not complete consensus concerning who really bears the burden of the payroll tax paid by employers. Some say that employees pay for it in the form of foregone wages. Others maintain that employers absorb part of it and pass the rest along to the general public in the form of higher prices. The resolution of this debate is beyond the scope of this discussion. However, including the employer share approximately doubles the present value of social security taxes and, therefore, approximately halves the ratio of the present value of benefits to taxes.

It is also possible to evaluate the relationship of taxes to benefits for HI—or part A of Medicare. HI is provided by a separately allocated share of the payroll tax, so the accumulated value of its taxes plus interest can be computed as shown in table 23. The annual value of its benefits for aged enrollees has been projected by the Congressional Budget Office, as shown in table 24.

TABLE 23.—CUMULATIVE HI TAXES PLUS INTEREST, 1966–90

Year	Tax rate (percent)	Interest rate (percent)	Earnings			Cumulative taxes + interest		
			Minimum earner	Average earner	Maximum earner	Minimum earner	Average earner	Maximum earner
1966..	0.35	3.483	$2,600	$4,938	$6,600	$9	$18	$24
1967..	.50	3.753	2,886	5,213	6,600	24	45	58
1968..	.60	3.950	3,293	5,572	7,800	45	81	108
1969..	.60	4,437	3,328	5,894	7,800	68	120	161
1970..	.60	5.074	3,328	6,186	7,800	92	165	217
1971..	.60	5.286	3,328	6,497	7,800	117	213	276
1972..	.60	5.406	3,328	7,134	9,000	144	269	347
1973..	1.00	5.754	3,328	7,580	10,800	186	362	478
1974..	.90	6.218	3,883	8,031	13,200	234	459	630
1975..	.90	6.593	4,368	8,631	14,100	290	570	802
1976..	.90	6.731	4,784	9,226	15,300	354	694	999
1977..	.90	6.958	4,784	9,779	16,500	423	833	1,222
1978..	1.00	7.199	5,512	10,556	17,700	511	1,002	1,493
1979..	1.05	7.524	6,032	11,479	22,900	615	1,203	1,855
1980..	1.05	8.568	6,448	12,513	25,900	738	1,443	2,297
1981..	1.30	9.947	6,968	13,773	29,700	907	1,774	2,931
1982..	1.30	11.178	6,968	14,531	32,400	1,104	2,172	3,703
1983..	1.30	10.768	6,968	15,239	35,700	1,318	2,614	4,590
1984..	1.30	11.601	6,968	16,135	37,800	1,567	3,140	5,642
1985..	1.35	11.213	6,968	16,823	39,600	1,841	3,731	6,839
1986..	1.45	11.091	6,968	17,322	42,000	2,152	4,410	8,240
1987..	1.45	10.063	6,968	18,427	43,800	2,475	5,134	9,736
1988..	1.45	9.777	6,968	19,334	45,000	2,823	5,930	11,372
1989..	1.45	9.559	6,968	20,100	48,000	3,198	6,802	13,187
1990..	1.45	9.248	7,670	21,179	51,300	3,610	7,752	15,184

Source: Congressional Research Service.

TABLE 24.—PROJECTED ANNUAL HI BENEFITS PER AGED ENROLLEE,[1] BY AGE AND SEX

[Current dollars]

Year	Age	Benefit	
		Male	Female
1991	65	$1,746	$1,550
1992	66	1,911	1,709
1993	67	2,088	1,882
1994	68	2,313	2,099
1995	69	2,553	2,335
1996	70	2,819	2,597
1997	71	3,112	2,888
1998	72	3,435	3,212
1999	73	3,793	3,573
2000	74	4,187	3,974
2001	75	4,623	4,420
2002	76	5,104	4,916
2003	77	5,635	5,468
2004	78	6,221	6,082
2005	79	6,868	6,764
2006	80	758	7,524
2007	81		8,369
2008	82		9,309
2009	83		9,319
Present value of HI benefits		31,448	40,852

[1] These are for workers only (i.e., does not include those entitled as dependents or survivors) and reflect the different life expectancies of males and females.

Source: Congressional Budget Office projections (January 1991).

The present value of Medicare part A benefits is $31,448 for a man and $40,852 for a woman. Unlike Social Security benefits, the amount of HI benefits for which one is eligible is not related to the level of one's earnings. The value of the HI benefits is constant across earnings levels (in reality, however, there may be differences in medicare utilization among the three groups). The HI projections shown in table 26 are based on this assumption. Including the value of the employer share of the taxes cuts these ratios in half.

Combining the Social Security and HI benefits and taxes presents a more complete picture of the relationship of payroll taxes and benefits for retirees. This is also shown in table 26.

The present value of the other part of Medicare—Supplementary Medical Insurance (SMI) or part B—also has been projected by the Congressional Budget Office and is shown in table 25. Including it in an analysis of the relationship of payroll taxes and benefits is problematic, however, because SMI is not financed by the payroll tax. Rather, three-quarters of its cost is borne by general revenues, with the remainder financed by premiums paid by the beneficiaries. It is valid, however, to include SMI as a measure of the value to the elderly of the total Social Security and Medicare benefit package. As displayed in tables 25 and 26, the present value of SMI

benefits was determined after subtracting the cost of the monthly premium.

TABLE 25.—PROJECTED SMI BENEFITS AND PREMIUMS PER AGED ENROLLEE, BY AGE AND SEX

[Current dollars]

Year	Age	Benefit		
		Male	Female	Premium
1991	65	$1,213	$1,077	$359
1992	66	1,367	1,222	382
1993	67	1,562	1,407	439
1994	68	1,777	1,613	493
1995	69	2,025	1,852	553
1996	70	2,307	2,126	578
1997	71	2,629	2,440	603
1998	72	2,997	2,802	629
1999	73	3,416	3,218	657
2000	74	3,894	3,696	686
2001	75	4,440	4,245	716
2002	76	5,063	4,876	748
2003	77	5,774	5,602	781
2004	78	6,585	6,437	815
2005	79	7,510	7,396	851
2006	80	857	8,499	888
2007	81	....	9,767	927
2008	82	....	11,225	968
2009	83	....	11,611	991
Present value of SMI benefits [1]		22,943	33,575	....

[1] Net of SMI premium.

Source: Congressional Budget Office Projections (February 1990).

TABLE 26.—PRESENT VALUES OF SOCIAL SECURITY AND HI TAXES AND SOCIAL SECURITY RETIREMENT BENEFITS, HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE (PARTS A AND B OF MEDICARE), 1991

	Earnings		
	Minimum earner	Average earner	Maximum earner
PRESENT VALUE OF BENEFITS			
Male:			
Social Security [1]	$70,938	$108,558	$147,862
HI	31,448	31,448	31,448
SMI [2]	22,943	22,943	22,943
Total	125,329	162,949	202,253
Female:			
Social Security [1]	85,468	130,787	178,148
HI	40,852	40,852	40,852
SMI [2]	33,575	33,575	33,575
Total	159,895	205,214	252,575
PRESENT VALUE OF TAXES			
Male and female-employee share:			
Social Security [3]	16,668	34,142	58,154
HI	3,610	7,752	15,184
Total employee	20,278	41,894	73,338
Total employee and employer	40,583	83,852	146,826
RATIO OF BENEFITS TO COMBINED EMPLOYEE AND EMPLOYER TAXES			
Male:			
Social Security	2.13	1.59	1.27
Social Security and HI	2.52	1.67	1.22
Social Security, HI and SMI	3.09	1.94	1.38
Female:			
Social Security	2.56	1.91	1.53
Social Security and HI	3.11	2.05	1.49
Social Security, HI and SMI	3.94	2.45	1.72
NET PRESENT VALUES—USING COMBINED EMPLOYEE AND EMPLOYER TAXES [4]			
Male:			
Social Security	$37,575	$40,211	$31,404
Social Security and HI	61,803	56,154	32,484
Social Security, HI and SMI	84,746	79,097	55,427
Female:			
Social Security	52,105	62,439	61,690
Social Security and HI	85,737	87,787	72,174
Social Security, HI and SMI	119,312	121,362	105,749

TABLE 26.—PRESENT VALUES OF SOCIAL SECURITY AND HI TAXES AND SOCIAL SECURITY RETIREMENT BENEFITS, HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE (PARTS A AND B OF MEDICARE), 1991—Continued

	Earnings		
	Minimum earner	Average earner	Maximum earner
PAYBACK TIMES—EMPLOYEE TAXES ONLY (YEARS)[5]			
Male:			
Social Security	3.0	4.2	5.3
Social Security and HI	2.8	4.2	5.8
Social Security, HI and SMI	2.5	3.8	5.4
Female:			
Social Security	3.0	4.2	5.3
Social Security and HI	2.9	4.3	5.9
Social Security, HI and SMI	2.6	4.0	5.5
PAYBACK TIMES—COMBINED EMPLOYEE AND EMPLOYER TAXES (YEARS)			
Male:			
Social Security	6.4	8.9	11.4
Social Security and HI	5.8	8.8	12.2
Social Security, HI and SMI	5.1	7.9	11.0
Female:			
Social Security	6.4	8.9	11.4
Social Security and HI	5.9	8.9	12.3
Social Security, HI and SMI	5.3	8.1	11.2

[1] Retirement benefits at age 65 or full career worker retiring January, 1991.

[2] Net of projected SMI premiums.

[3] The portion of the social security tax attributable to payment of retirement benefits.

[4] The present value of benefits minus the present value of employee-employer taxes.

[5] The number of years it takes to recover the present value of taxes paid.

Source: Congressional Research Service.

Sensitivity analysis

Table 27 shows the sensitivity of the foregoing analysis to certain assumptions. As mentioned earlier, the rate of interest is crucial in determining present values. The table shows the effect on the value of future Social Security, HI, and SMI benefits of a real rate of interest one percentage point higher or lower than that used in the II-B assumptions of the 1990 Report of the Social Security Board of Trustees.

Benefits and taxes also vary for those with less than full work careers. For illustrative purposes, the work history in table 27 was varied by assuming that there were 5 years with no earnings. As can be seen, there is little or no difference in taxes or benefits for workers who began their career at age 26. However, a different picture emerges for those who have gaps late in their careers. Their taxes are significantly lower, and their benefits are somewhat lower, than workers who work until age 65. This difference is due in part to the real increase in recent years in the maximum taxable wage base and in part to the higher value of wages earned after age 60, when they are no longer indexed. The effect on the present value of taxes and benefits is also shown for a worker who takes early retirement at age 62.

The table also shows the effect on taxes and benefits of early retirement at age 62, and of "dropout years," in which the worker leaves the workforce to care for children or other dependent family members. In this illustration, the worker is assumed to been out of the workforce for 10 years, from ages 26–35.

Because the projected amount of future benefits depends directly on how long they are received, table 27 also illustrates the effect of different life expectancies on the present value of benefits.

TABLE 27.—SENSITIVITY ANALYSIS FOR MALE WORKER [1]

	Earnings		
	Minimum	Average	Maximum
Discount rate (real):			
Present value of benefits:			
3 percent	$117,261	$152,668	$184,658
2 percent	125,329	162,949	202,253
1 percent	136,410	177,077	219,564
Work history: [2]			
Full career:			
Present value of benefits	125,329	162,949	202,253
Present value of taxes	40,583	83,852	146,826
Net present value	84,746	79,097	55,427
Begin at age 26:			
Present value of benefits	125,049	162,949	202,100
Present value of taxes	39,692	81,966	144,457
Net present value	85,357	80,983	57,643
Dropout (no earnings) age 26–35:			
Present value of benefits	120,649	158,199	198,872
Present value of taxes	35,864	74,951	136,248
Net present value	84,785	83,248	62,624
End at age 60:			
Present value of benefits	125,329	161,640	193,751
Present value of taxes	35,538	70,237	114,319
Net present value	89,791	91,403	79,432
Early retirement: [3]			
Retire at age 62:			
Present value of benefits	122,401	155,857	189,583
Present value of taxes	40,276	82,986	145,717
Net present value	82,125	72,871	43,866
Life expectancy:			
Present value of benefits:			
Standard assumption	125,329	162,949	202,253
3 years less	98,139	129,257	161,768
3 years more	141,224	184,965	230,671

[1] Benefits in these examples are social security, HI, and SMI combined, and taxes include the employer share of social security and HI taxes.

[2] Examples assume male worker retires at age 65 (including worker who ceases to work at age 60) and begins work at age 21 (except for the worker specified as beginning work at age 26).

[3] The life expectancy of males retiring at age 62 in 1991 is 17.2 years.

Source: Congressional Research Service.

APPENDIX I. POVERTY, INCOME DISTRIBUTION AND ANTIPOVERTY EFFECTIVENESS [1]

This appendix presents statistics which describe the poverty, income and wealth status of individuals and/or families. It covers the following topics:

—measuring poverty, trends in the overall poverty rate, poverty rates for individuals in selected subgroups, geographic differences in poverty, the working poor, poverty rates by family type, international poverty comparisons for families;

—antipoverty effectiveness of various cash, near-cash, and noncash income sources for all individuals in: families or living alone, families with children, female-headed families with children, married-couple families with children, and families with all members age 65 and over;

—explanations for increases in poverty between 1979 and 1987 and 1988; and

—trends in family income and income inequality.

POVERTY STATISTICS

MEASURING POVERTY

When the Federal Government began measuring poverty in the early 1960's, the continued existence of poor people in a time of the "Affluent Society" seemed anomalous. Official concern soon translated into efforts to measure the size of the poverty population, and the search began for programmatic ways to alleviate poverty. The first rough estimates of the incidence of poverty were based on survey data indicating that families generally spent about one-third of their income on food. A poverty level income was then calculated by using as a yardstick the amount of money necessary to purchase the lowest cost "nutritionally adequate" diet calculated by the Department of Agriculture (roughly equivalent to the current Thrifty Food Plan). This price tag was multiplied by 3 to produce a poverty threshold. This procedure assumed, then, that if a family did not have enough income to buy the lowest cost nutritionally adequate diet, and twice that amount to buy other goods and services, it was "poor." Adjustments were made for the size of the family, the sex of the family head, and for whether or not the family lived on a farm. Farm families were assumed to need less cash income because their needs could be met partially by farm products, particularly food. The adjustments for sex of the family head and for farm-nonfarm residence were abolished in 1981. Policy officials made one change to the basic approach for calculating the poverty threshold in 1969. The current poverty threshold is established each year simply by increasing the previous year's threshold by the change in the Consumer Price Index (CPI), rather than multiplying the cost of the Thrifty Food Plan by three. The poverty thresholds for selected years are shown in table 1.

---

[1] See Appendix G and Appendix H for additional poverty and income data related to individuals in families with children and the elderly.

Note that the tables in this subsection provide poverty data calculated using the official census definition of poverty. The census definition of poverty has remained fairly standard over time and is useful for measuring progress against poverty. Under this definition, poverty is determined by comparing pretax cash income with the poverty threshold.

It should be noted that the Census Bureau revised its method of estimating the poverty threshold four times—in 1966, 1974, 1979, and 1981. These revisions changed the estimate of the poverty rate. The first two revisions slightly reduced the estimated number of poor, while the more recent revisions slightly increased the number. In 1984, the Census Bureau also revised its method of imputing missing values for interest income, which slightly lowered the estimated poverty rate.

The 1988 and 1989 income and poverty data may not be comparable to data in earlier years because of changes in the methods used by the Census Bureau to process survey results. This new processing system was applied to 1987 data so that 1988 and 1987 data are comparable. Revised 1987 data are denoted as 1987R. The new processing system increased aggregate income by 0.9 percent and lowered the poverty rate for 1987 by 0.1 percent.

TABLE 1.—WEIGHTED AVERAGE POVERTY THRESHOLDS FOR NONFARM FAMILIES OF SPECIFIED SIZE, SELECTED YEARS, 1959–89

Calendar year	Unrelated individuals			Families of 2 or more persons							
				2 persons							
	All ages	Under age 65	Aged 65 or older	All ages	Head under age 65	Head aged 65 or older	3 persons	4 persons	5 persons	6 persons	7 persons or more
1959	$1,467	$1,503	$1,397	$1,894	$1,952	$1,761	$2,324	$2,973	$3,506	$3,944	$4,849
1960	1,490	1,526	1,418	1,924	1,982	1,788	2,359	3,022	3,560	4,002	4,921
1965	1,582	1,626	1,512	2,048	2,114	1,906	2,514	3,223	3,797	4,264	5,248
1970	1,954	2,010	1,861	2,525	2,604	2,348	3,099	3,968	4,680	5,260	6,468
1975	2,724	1,797	2,581	3,506	3,617	3,257	4,293	5,500	6,499	7,316	9,022
1976	2,884	2,959	2,730	3,711	3,826	3,445	4,540	5,815	6,876	7,760	9,588
1977	3,075	3,152	2,906	3,951	4,072	3,666	4,833	6,191	7,320	8,261	10,216
1978	3,311	3,392	3,127	4,249	4,383	3,944	5,201	6,662	7,880	8,891	11,002
1979	3,689	3,778	3,479	4,725	4,878	4,390	5,784	7,412	8,775	9,914	12,280
1980	4,190	4,290	3,949	5,363	5,537	4,983	6,565	8,414	9,966	11,269	[1] 12,761
1981	4,620	4,729	4,359	5,917	6,111	5,498	7,250	9,287	11,007	12,449	[1] 14,110
1982	4,901	5,019	4,626	6,281	6,487	5,836	7,693	9,862	11,684	13,207	[1] 15,036
1983	5,061	5,180	4,775	6,483	6,697	6,023	7,938	10,178	12,049	13,630	[1] 15,500
1984	5,278	5,400	4,979	6,762	6,983	6,282	8,277	10,609	12,566	14,207	[1] 16,096
1985	5,469	5,593	5,156	6,998	7,231	6,503	8,573	10,989	13,007	14,696	[1] 16,656
1986	5,572	5,702	5,255	7,138	7,372	6,630	8,737	11,203	13,259	14,986	[1] 17,049
1987	5,778	5,909	5,447	7,397	7,641	6,872	9,056	11,611	13,737	15,509	[1] 17,649
1988	6,024	6,155	5,674	7,704	7,958	7,158	9,435	12,092	14,305	16,149	[1] 18,248
1989	6,311	6,452	5,947	8,076	8,343	7,501	9,885	12,675	14,990	16,921	[1] 19,162

[1] Poverty threshold for 7 persons, not 7 persons or more.

Source: Bureau of the Census, technical papers.

TRENDS IN THE OVERALL POVERTY RATE [2]

Table 2, which covers the time period 1959 through 1989, presents historical poverty data.

In the late 1950's, the overall poverty rate for individuals in the United States was 22 percent, representing 39.5 million poor persons. Between 1959 and 1969, the poverty rate declined dramatically and steadily to 12.1 percent. As a result of a sluggish economy, the rate increased slightly to 12.5 percent by 1971. In 1972 and 1973, however, it began to decrease again. The lowest rate over the entire 24-year period occurred in 1973, when the poverty rate was 11.1 percent. At that time roughly 23 million people were poor, 42 percent less than were poor in 1959.

The poverty rate increased by 1975 to 12.3 percent, and then oscillated around 11.5 percent through 1979. After 1978, however, the poverty rate rose steadily reaching 15.2 percent in 1983. In 1989, the last year for which data are available, the poverty rate was 12.8 percent and 31.5 million people were poor.

POVERTY RATES FOR INDIVIDUALS IN SELECTED SUBGROUPS OF THE POPULATION

As table 2 also illustrates, there are substantial differences between the overall poverty rate and the poverty rates of individuals in certain demographic subgroups. Most notably, blacks, individuals in female-headed households, and Hispanics have poverty rates that greatly exceed the average. The poverty rates for blacks and individuals in female-headed households remained above 30 percent over the 1959 through 1989 period. The poverty rate for all Hispanics has remained near 30 percent during the 1980's. The poverty rate for the aged, which exceeded the overall poverty rate in 1959, fell below the overall poverty rate beginning in 1982. It was 11.4 percent in 1989. The poverty rate for whites was below the overall poverty rate throughout the entire 1959–1989 period. It was 10.0 percent in 1989.

The poverty rate for children also exceeds the average rate; it remained above 14 percent during the 1959 to 1989 period and was 19.6 percent in 1989.

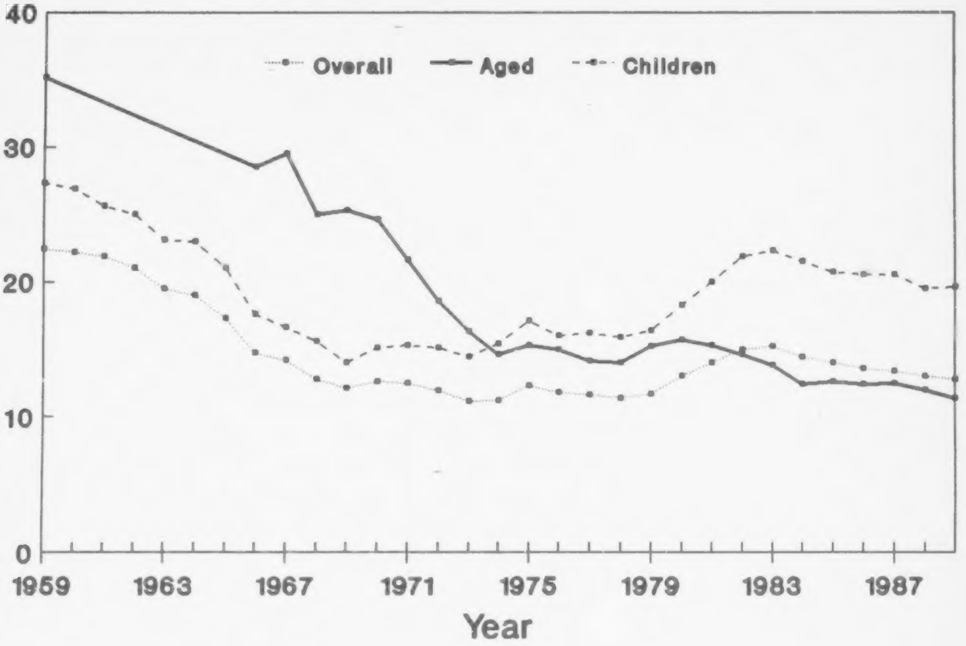
---

[2] All poverty trend information is based upon published Census Bureau data contained in "Money Income and Poverty Status of Families: 1978," P-60. No. 124; "Money Income and Poverty Status of Families: 1982," P-60, No. 140; "Money Income and Poverty Status of Families and Persons in the United States: 1983," P-60. No. 145; "Money Income and Poverty Status of Families and Persons in the United States: 1984," P-60. No. 149; "Money Income and Poverty Status of Families: 1985," P-60. No. 154; and "Money Income and Poverty Status of Families: 1986," P-60, No. 157; "Money Income and Poverty Status in the United States: 1987," P-60, No. 161; "Money Income and Poverty Status in the United States: 1988," P-60, No. 166 and "Money Income and Poverty Status in the United States: 1989" P-60, No. 168. These figures may differ with other parts of this report which provide a more refined breakdown of this age category. Data for blacks, the aged, and nonaged population were not available for the years 1961 to 1965.

GEOGRAPHIC DIFFERENCES IN POVERTY [3]

Poverty rates by State are provided in Appendix J. Table 3 provides 1989 poverty data by region. The rest of this subsection outlines rural/urban differences in poverty.[4]

CHART 1. POVERTY RATES OF AGED, CHILDREN, AND OVERALL POPULATION, 1959–89



---

[3] This section draws from "The Rural Poor: Policy Issues for the 1990's," by Kenneth L. Deavers, Robert A. Hoppe, and Peggy J. Ross, Economic Research Service, U.S. Department of Agriculture, undated.

[4] The terms "urban" and "metro" are used synonymously to describe those areas designated by the Bureau of the Census as metropolitan statistical areas (MSA). The Census Bureau defines a metropolitan statistical area as "a geographic area consisting of a large population nucleus, together with adjacent communities which have a high degree of economic and social integration with that nucleus. The definitions specify a boundary around each large city so as to include most or all of its suburbs. Entire counties form the MSA building blocks, except in New England where cities and towns are used." (Bureau of the Census, U.S. Department of Commerce, Poverty in the United States: 1985, Series P–60, No. 158, October 1989, p. 159)

The terms "rural" and "nonmetro" are likewise used to describe those areas that the Census Bureau designates as being outside a metropolitan statistical area.

The term "central city" is used as defined by the Census Bureau to mean the largest city or cities in a metropolitan statistical area.

TABLE 2.—NUMBER OF PERSONS IN POVERTY AND POVERTY RATE FOR INDIVIDUALS IN SELECTED DEMOGRAPHIC GROUPS, 1959–89

Year	Overall	Aged	Children [1]	Individuals in female-headed families [2]	Blacks	Hispanic origin [3]	Whites
Number below poverty (thousands)							
1959	39,490	5,481	17,552	7,014	9,927	NA	28,484
1960	39,851	NA	17,634	7,247	NA	NA	28,309
1961	39,628	NA	16,909	7,252	NA	NA	27,890
1962	38,625	NA	16,963	7,781	NA	NA	26,672
1963	36,436	NA	16,005	7,646	NA	NA	25,238
1964	36,055	NA	16,051	7,297	NA	NA	24,957
1965	33,185	NA	14,676	7,524	NA	NA	22,496
1966	28,510	5,114	12,389	6,861	8,867	NA	19,290
1967	27,769	5,388	11,656	6,898	8,486	NA	18,983
1968	25,389	4,632	10,954	6,990	7,616	NA	17,395
1969	24,147	4,787	9,691	6,879	7,095	NA	16,659
1970	25,420	4,793	10,440	7,503	7,548	NA	17,484
1971	25,559	4,273	10,551	7,797	7,396	NA	17,780
1972	24,460	3,738	10,284	8,114	7,710	2,414	16,203
1973	22,973	3,354	9,642	8,178	7,388	2,366	15,142
1974	23,370	3,085	10,156	8,462	7,182	2,575	15,736
1975	25,877	3,317	11,104	8,846	7,545	2,991	17,770
1976	24,975	3,313	10,273	9,029	7,595	2,783	16,713
1977	24,720	3,177	10,288	9,205	7,726	2,700	16,416
1978	24,497	3,233	9,931	9,269	7,625	2,607	16,259
1979	26,072	3,682	10,377	9,400	8,050	2,921	17,214
1980	29,272	3,871	11,543	10,120	8,579	3,491	19,699
1981	31,822	3,853	12,505	11,051	9,173	3,713	21,553
1982	34,398	3,751	13,647	11,701	9,697	4,301	23,517
1983	35,303	3,625	13,911	12,072	9,882	4,633	23,984
1984	33,700	3,330	13,420	11,831	9,490	4,806	22,955
1985	33,064	3,456	13,010	11,600	8,926	5,236	22,860
1986	32,370	3,477	12,876	11,944	8,983	5,117	22,183
1987	32,341	3,564	12,963	12,278	9,577	5,442	21,249
1988 (revised)	31,745	3,481	12,455	11,972	9,356	5,357	20,715
1989	31,534	3,369	12,590	11,668	9,305	5,430	20,788
Poverty rate (percent)							
1959	22.4	35.2	27.3	49.4	55.1	NA	18.1
1960	22.2	NA	26.9	48.9	NA	NA	17.8
1961	21.9	NA	25.6	48.1	NA	NA	17.4
1962	21.0	NA	25.0	50.3	NA	NA	16.4
1963	19.5	NA	23.1	47.7	NA	NA	15.3
1964	19.0	NA	23.0	44.4	NA	NA	14.9
1965	17.3	NA	21.0	46.0	NA	NA	13.3
1966	14.7	28.5	17.6	39.8	41.8	NA	11.3
1967	14.2	29.5	16.6	38.8	39.3	NA	11.0

TABLE 2.—NUMBER OF PERSONS IN POVERTY AND POVERTY RATE FOR INDIVIDUALS IN SELECTED DEMOGRAPHIC GROUPS, 1959–89—Continued

Year	Overall	Aged	Children [1]	Individuals in female-headed families [2]	Blacks	Hispanic origin [3]	Whites
1968	12.8	25.0	15.6	38.7	34.7	NA	10.0
1969	12.1	25.3	14.0	38.2	32.2	NA	9.5
1970	12.6	24.6	15.1	38.1	33.5	NA	9.9
1971	12.5	21.6	15.3	38.7	32.5	NA	9.9
1972	11.9	18.6	15.1	38.2	33.3	22.8	9.0
1973	11.1	16.3	14.4	37.5	31.4	21.9	8.4
1974	11.2	14.6	15.4	36.5	30.3	23.0	8.6
1975	12.3	15.3	17.1	37.5	31.3	26.9	9.7
1976	11.8	15.0	16.0	37.3	31.1	24.7	9.1
1977	11.6	14.1	16.2	36.2	31.3	22.4	8.9
1978	11.4	14.0	15.9	35.6	30.6	21.6	8.7
1979	11.7	15.2	16.4	34.9	31.0	21.8	9.0
1980	13.0	15.7	18.3	36.7	32.5	25.7	10.2
1981	14.0	15.3	20.0	38.7	34.2	26.5	11.1
1982	15.0	14.6	21.9	40.6	35.6	29.9	12.0
1983	15.2	13.8	22.3	40.2	35.7	28.0	12.1
1984	14.4	12.4	21.5	38.4	33.8	28.4	11.5
1985	14.0	12.6	20.7	37.6	31.3	29.0	11.4
1986	13.6	12.4	20.5	38.3	31.1	27.3	11.0
1987	13.4	12.5	20.5	38.3	32.6	28.1	10.4
1988 (revised)	13.0	12.0	19.5	37.2	31.3	26.7	10.1
1989	12.8	11.4	19.6	35.9	30.7	26.2	10.0

[1] All children including unrelated children.

[2] Does not include females living alone.

[3] Hispanic origin may be of any race; it is an overlapping category.

NA—Not available.

Source: Bureau of the Census, Technical Paper 56, table 1; series P–60: No. 134, table 15; No. 140, table 15; No. 145, table 15; No. 149, table 15; No. 152, table 1; No. 154, table 16; No. 157, tables 15 and 16; No. 161, table 18; No. 166, tables 18 and 19; and No. 168, tables 19 and 20.

TABLE 3.—POVERTY BY REGION, 1989

	Number below poverty (thousands)				Poverty rate (percent)			
	All races	White	Black	Hispanic	All races	White	Black	Hispanic
Northeast	5,061	3,502	1,303	958	10.0	8.0	24.7	29.6
Midwest	7,043	4,718	2,181	352	11.9	9.0	36.4	24.7
South	12,943	7,498	5,222	1,855	15.4	11.4	31.6	28.7
West	6,487	5,070	601	2,266	12.5	11.3	23.5	23.6

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States," report for 1989 (table 22).

As table 4 demonstrates, rural poverty is a very real phenomenon. On average across the United States, the poverty rate for rural areas exceeds the poverty rate for urban metropolitan areas. Rural poverty rates are almost as high as, and in 1986 even exceeded, poverty rates of the central city sections of metropolitan areas.

Between 1978 and 1989, the poverty rate in nonmetro areas increased more quickly than the poverty rate in the overall metro areas and the central city sections of the metro areas. Between 1986 and 1989, however, poverty rates actually declined in nonmetro areas and increased in metropolitan areas. It appears that the major reason that poverty rates declined in nonmetro areas is that the poverty rate of farm residents decreased significantly.

Differences in rural and urban poverty are also apparent in the work status of the poor. The data at the top of table 6 shows that close to 50 percent of the household heads in poor families worked during 1987. The data also highlight that household heads in nonmetro areas tend to work more than household heads in metro areas.

TABLE 4.—POVERTY RATES IN NONMETRO AND METRO AREAS, 1978–89

[Percent of persons]

	Nonmetro	Metro	
		Total	Central cities only
1978	13.5	10.4	15.4
1979	13.8	10.7	15.7
1980	15.4	11.9	17.2
1981	17.0	12.6	18.0
1982	17.8	13.7	19.9
1983	18.3	13.8	19.8
1984	NA	NA	NA
1985	18.3	12.7	19.0
1986	18.1	12.3	18.0
1987	16.9	12.5	18.6
1989	15.7	12.0	18.1
Percent increase, 1978–89	16.3	15.4	17.5

NA—Not available.

Table 5 shows that poverty rates were higher in 1989 in rural areas than metropolitan areas for every race classification. Further, when broken down by race, poverty rates in rural areas exceeded poverty rates in central cities for both blacks and Hispanics. For example, Hispanics had a poverty rate of 34.3 percent in nonmetro areas and 29.7 percent in central cities. For blacks, the rural/central city differences were even greater: the nonmetro poverty rate was 39.6 percent and the central city rate was 33.1 percent.

Differences between rural and urban area poverty are also apparent in the family composition of the poor. The rural poor, more than the urban poor, tend to be comprised of families with two parents. In 1986 more than one-half of the poor in nonmetro areas lived in two-parent families, whereas roughly 35 percent of the poor in metro areas lived in such households.

TABLE 5.—PERCENT OF PERSONS IN POVERTY BY RACE, AND COMPOSITION OF THE POVERTY POPULATION BY FAMILY TYPE, 1989

	Nonmetro	Metro	
		Total	Central cities only
1989:			
All races	15.7	12.0	18.1
White	13.1	9.1	13.2
Black	39.6	28.9	33.1
Hispanic	34.3	25.5	29.7

Source: 1989 data are from the Bureau of the Census, Money Income and Poverty Status of Families and Persons in the United States: 1989, Table 22.

Focusing exclusively on the work history of household heads may understate the work effort of the poor, because family members other than the household head may work. The number of workers per poor family is a much better gauge of the work effort of the poor. As table 6 also shows, in 1986 about two-thirds of nonmetro poor families had at least one worker, and more than one-fourth had two or more workers. By contrast, in metro areas, slightly more than one-half of the families that were poor had one or more members working. This difference in work is undoubtedly related to the fact that the poor in nonmetro areas are more likely to live in married-couple families. Married-couple families are more likely to contain two potential workers, while female-headed families are more likely to contain only one potential worker.

TABLE 6.—WORK STATUS OF FAMILIES IN POVERTY, BY METRO AND NONMETRO RESIDENCE

	Metro	Nonmetro
1987:		
Percent of poor household heads who work	44.0	54.7
Full-year	17.1	23.4
Full-time	12.8	18.8
Part-year	26.8	31.3
Full-time	17.0	19.5
Percent of poor household heads who do not work	56.0	45.3

TABLE 6.—WORK STATUS OF FAMILIES IN POVERTY, BY METRO AND NONMETRO RESIDENCE—Continued

	Metro	Nonmetro
1986:		
Percent of poor families with:		
No workers	43.7	32.5
One worker	39.4	38.6
Two or more workers	16.8	28.9
Total	100.0	100.0

Source: U.S. Bureau of the Census.

Table 7 shows poverty statistics by State from 1969 to the late 1980s. Overall, poverty rates have fluctuated across the United States since 1969, both rising and falling. While the average U.S. poverty rates are fairly equal at 13.7 and 13.4 for 1969 and the late 1980s respectively, 11 States had poverty rates over 20.0 in 1969 compared to only 6 States in the late 1980s.

TABLE 7.—POVERTY STATISTICS BY STATE

State	Poverty rate				
	1969 [1]	1975 [2]	1979 [3]	Mid-1980s [4]	Late 1980s
Total	13.7	11.4	12.4	14.0	13.4
Connecticut	7.2	6.7	8.0	7.2	6.3
Maine	13.6	12.0	13.0	11.1	11.6
Massachusetts	8.6	7.1	9.6	8.8	8.9
New Hampshire	9.1	7.9	8.5	5.6	4.6
Rhode Island	11.0	8.7	10.3	11.2	8.8
Vermont	12.1	13.5	12.0	10.2	10.2
Delaware	10.9	8.2	11.8	11.3	9.8
District of Columbia	17.0	12.5	18.6	19.2	13.2
Maryland	10.1	7.7	9.8	8.5	8.3
New Jersey	8.1	8.1	9.5	9.5	8.1
New York	11.1	9.4	13.4	15.2	13.6
Pennsylvania	10.6	9.7	10.5	12.4	10.2
Illinois	10.2	10.5	11.0	15.0	13.0
Indiana	9.7	8.1	9.7	12.2	11.2
Michigan	9.4	9.1	10.4	14.4	12.9
Ohio	10.0	9.4	10.3	12.4	12.9
Wisconsin	9.8	7.7	8.7	11.8	8.6
Iowa	11.6	7.9	10.1	16.5	12.8
Kansas	12.7	8.0	10.1	11.2	9.7
Minnesota	10.7	8.3	9.5	11.5	11.4
Missouri	14.7	12.0	12.2	14.3	14.5
Nebraska	13.1	9.6	10.7	14.6	12.5
North Dakota	15.7	10.6	12.6	14.9	12.3
South Dakota	18.7	13.1	16.9	16.2	15.9
Alabama	25.4	16.4	18.9	21.5	21.6
Arkansas	26.8	18.5	19.0	22.2	21.8

TABLE 7.—POVERTY STATISTICS BY STATE—Continued

State	Poverty rate				
	1969 [1]	1975 [2]	1979 [3]	Mid-1980s [4]	Late 1980s
Florida	16.4	14.4	13.4	13.3	12.5
Georgia	20.7	18.0	16.6	15.6	14.4
Kentucky	22.9	17.7	17.6	18.5	17.8
Louisiana	26.3	19.3	18.6	20.8	22.5
Mississippi	35.4	26.1	23.9	25.6	25.8
North Carolina	20.3	14.7	14.8	14.0	13.7
South Carolina	23.9	17.2	16.6	17.6	16.0
Tennessee	21.8	15.8	16.4	17.8	18.4
Virginia	15.5	10.5	11.8	10.6	10.4
West Virginia	22.2	15.1	15.0	22.8	21.6
Arizona	15.3	13.8	13.2	13.4	13.6
New Mexico	22.8	19.3	17.6	20.7	20.6
Oklahoma	18.8	13.8	13.4	15.5	16.6
Texas	18.8	15.2	14.7	16.2	17.7
Colorado	12.3	9.1	10.1	10.8	12.7
Idaho	13.2	10.3	12.6	16.4	15.4
Montana	13.6	11.5	12.3	16.3	16.8
Utah	11.4	8.5	10.3	11.9	10.8
Wyoming	11.7	8.7	7.9	12.3	11.8
California	11.1	10.4	11.4	13.4	12.7
Nevada	9.1	8.8	8.7	12.4	9.1
Oregon	11.5	8.9	10.7	12.6	11.8
Washington	10.2	8.5	9.8	11.7	11.3
Alaska	12.6	6.7	10.7	10.4	11.0
Hawaii	9.3	7.9	9.9	9.9	9.7

[1] U.S. Bureau of the Census, Statistical Abstract of the United States: 1979, table 764, pp. 465 (110th edition), Washington, D.C. 1979, 1969 estimates are from the 1970 census.

[2] Data are also from the 1979 Statistical Abstract of the United States, but estimates are from the Survey of Income and Education.

[3] U.S. Bureau of the Census, Statistical Abstract of the United States: 1982–83, table 732, p. 443. (103d edition.) Washington, D.C. 1982. 1979 estimates are from the 1980 census.

[4] Data from "Poverty Rates in the mid-1980s: An Update," Robert D. Plotnick and Sheldon Danzinger, Institute for Research on Poverty, University of Wisconsin—Madison, Fall 1988.

THE WORKING POOR

People can work and still be poor for many reasons. Workers may not work the entire year due to the loss of a job, inability to find full-time, full-year work, illness or disability, or other family responsibilities. Even full-time workers may not earn enough to keep a family, particularly a large family, out of poverty.

Tables 8 and 9 provide data on the work status of families with children. Table 8 answers the question: "Of all poor (or nonpoor) families with children, what percent work?" Table 9 answers the question: "Of all families with children and who work, what percent are poor?" The tables show the total hours worked in a year by all family members who worked, expressed in terms of the number of "full-time worker equivalents". A full-time worker equivalent (FTWE) is defined as between 1,750 and 2,080 hours of work over the course of the year (i.e., between the equivalent of 35 hours per week for 50 weeks, and 40 hours per week for 52 weeks).

Table 8 shows that in 1989, 62.9 percent of all poor families with children had someone who worked during the year, whereas nearly all nonpoor families with children (98.7 percent) had someone who worked during the year. Approximately 28 percent of all poor families with children had the equivalent of 1 or more persons working full-time, full-year, when measured in terms of the total number of hours family members worked. Looking at poor families, 55.2 percent of poor married-couple families with children had the equivalent of 1 or more full-time workers, compared to only 12.7 percent of poor female-headed families.

A comparison of the amount of work supplied by families with children in 1979 and 1989 reveals that married couple families are working more today than they did 10 years ago. This is not so for single female-headed families; their work status remains about the same as in 1979. While the percent of married-couple families with children and who have at least one member working was not appreciably different in 1989 than 10 years earlier, the total number of hours worked by family members, as measured in terms of full-time worker equivalents, was greater. In 1989, 66.3 percent of all married-couple families with children had members who worked the equivalent of 1.5 or more full-time workers, compared to 56.5 percent of all such families in 1979.

Table 9 shows the poverty rates of families with children, according to the amount they worked during the year. The table shows that the poverty rate for families with children was higher in 1989 than it was in 1979. In 1989, 16.0 percent of families with children were poor; in 1979, 12.7 percent. The poverty rate was higher in 1989 than in 1979 for both married-couple and female-headed families. In 1989, 7.4 percent of married couple families were poor, compared to 6.1 percent in 1979; 43.7 percent of female-headed families were poor in 1989, compared to 39.6 percent 10 years earlier.

The incidence of poverty was higher for both married-couple and female-headed families in 1989 than in 1979, for families with significant work effort, as well as those with marginal or no work effort. For example, 15.2 percent of female-headed families with children having significant work effort (0.75 full-time worker equivalents or more) were poor in 1989, compared to 11.1 percent in 1979.

TABLE 8.—THE WORK STATUS OF FAMILIES WITH CHILDREN, BY FAMILY TYPE AND POVERTY STATUS, 1979 AND 1989

[In percent]

	All families with children			Married couple families with children			Female-headed families with children		
	Total	Poor	Non-poor	Total	Poor	Non-poor	Total	Poor	Non-poor
1979:									
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No work	6.4	36.7	2.0	2.3	16.2	1.4	22.9	50.0	5.1
Some work	93.6	63.3	98.0	97.7	83.8	98.0	77.1	50.0	94.9
0.25 FTWE or more	91.3	51.3	97.1	96.7	76.7	98.0	69.2	34.8	91.7
0.50 FTWE or more	89.2	42.3	96.0	95.6	69.8	97.3	63.1	24.7	88.2
0.75 FTWE or more	86.2	33.7	93.9	93.8	62.1	95.9	55.7	15.6	81.9
1.00 FTWE or more	82.7	26.4	90.9	91.2	52.4	93.8	48.4	10.0	73.6
1.50 FTWE or more	47.4	8.6	53.3	56.5	19.8	58.9	13.7	1.6	21.6
1989:									
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No work	7.0	37.1	1.3	1.7	13.5	0.7	24.2	50.7	3.7
Some work	93.0	62.9	98.7	98.3	86.5	99.3	75.8	49.3	96.3
0.25 FTWE or more	90.8	52.4	98.2	97.6	80.2	99.0	68.8	36.1	94.2
0.50 FTWE or more	88.9	44.0	97.5	96.8	72.7	98.7	63.4	27.8	91.1
0.75 FTWE or more	86.4	36.0	96.0	95.5	64.3	98.0	57.1	19.9	85.9
1.00 FTWE or more	83.1	28.1	93.6	93.6	55.2	96.7	49.8	12.7	78.6
1.50 FTWE or more	52.5	8.2	61.0	66.3	20.3	69.9	13.2	1.8	22.1

Note: Families include "unrelated subfamilies". The total number of hours worked by family members during the year is expressed in terms of "full-time worker equivalents". A full-time worker equivalent (FTWE) is defined as from 1,750 hours worked during the year (the equivalent of 35 hours of work per week for 50 weeks during the year) up to 2,080 hours worked during the year (40 hours of work per week for 52 weeks during the year). Categories for families working less than 1 FTWE are defined on the basis of the lower bound of 1,750 hours for a full-time worker equivalent. The category of 1.5 FTWE or more is defined as 2,790 hours or more of work during the year (i.e., half way between the upper bound of 1 FTWE (2,080 hours) and the lower bound of 2 FTWEs (3,500 hours)).

Source: Calculations by Congressional Research Service (CRS) using data from the March 1980 and March 1990 Current Population Surveys (CPS).

Table 10 shows the number of families with children who worked, yet remained poor in 1979 and 1989. The table shows that in 1989 3.5 million families with children had some work and were poor. Approximately 2 million families were poor, even though they had significant work (0.75 full-time worker equivalents or more). The majority of these poor families (60 percent) were married couple families.

TABLE 9.—POVERTY STATUS OF FAMILIES WITH CHILDREN, BY WORK STATUS AND FAMILY TYPE, 1979 AND 1989

[Percent of families that are poor]

	Total		Married couple families		Female-headed families	
	1979	1989	1979	1989	1979	1989
Total	12.7	16.0	6.1	7.4	39.6	43.7
No work	73.1	84.8	42.7	59.3	86.4	91.4
Some work	8.6	10.9	5.3	6.5	25.7	28.4
Number of full-time worker equivalents:						
Up to 0.75 FTWE	51.1	65.1	34.6	58.7	63.5	68.6
0.75 FTWE or more	5.0	6.7	4.1	5.0	11.1	15.2

Note: Families include "unrelated subfamilies". The total number of hours worked by family members during the year is expressed in terms of "full-time worker equivalents". A full-time worker equivalent (FTWE) is defined as from 1,750 hours worked during the year (the equivalent of 35 hours of work per week for 50 weeks during the year) up to 2,080 hours worked during the year (40 hours of work per week, for 52 weeks during the year). The category, 0.75 FTWE or more is defined as 1,312 or more hours of work during the year (0.75 of 1,750 hours).

Source: Estimates by the Congressional Research Service (CRS) using data from the March 1980 and March 1990 Current Population Surveys (CPS).

TABLE 10.—NUMBER OF FAMILIES (WITH CHILDREN) WHO WORK AND YET REMAIN POOR, 1979 AND 1989, BY FAMILY TYPE

[In thousands of families]

	All families		Married-couple families		Female-headed families	
	1979	1989	1979	1989	1979	1989
Total poor	4,082	5,576	1,545	1,878	2,425	3,434
No work	1,499	2,067	251	253	1,212	1,740
Some work	2,583	3,509	1,295	1,624	1,213	1,694
Up to 0.75 FTWE	1,207	1,502	335	416	833	1,010
0.75 FTWE or more	1,376	2,007	960	1,208	379	684

Note: Families include "unrelated subfamilies". The total number of hours worked by family members during the year is expressed in terms of "full-time worker equivalents". A full-time worker equivalent (FTWE) is defined as from 1,750 hours worked during the year (the equivalent of 35 hours of work per week for 50 weeks during the year) up to 2,080 hours worked during the year (40 hours of work per week, for 52 weeks during the year). The category, 0.75 FTWE or more is defined as 1,312 or more hours of work during the year (0.75 of 1,750 hours).

Source: Estimates by the Congressional Research Service (CRS) using data from the March 1980 and March 1990 Current Population Surveys (CPS).

COMPOSITION OF THE POVERTY POPULATION

The composition of the poverty population changes over time as both the relative size of the various subgroups of the population change and as the poverty rates of different subgroups change.

Table 11 presents data on the composition of the poverty population, broken down by selected subgroups of the population for several years between 1959 and 1989.

TABLE 11.—COMPOSITION OF POVERTY POPULATION FOR SELECTED DEMOGRAPHIC GROUPS [1]

[Percent of poverty population]

	1959	1966	1975	1982	1983	1985	1987	1987R	1988	1989
Aged	13.9	17.9	12.8	10.9	10.5	10.5	10.7	10.9	11.0	10.7
Children	43.6	42.6	42.1	39.2	39.0	38.8	39.4	39.4	38.7	39.4
Nonaged adults	42.5	39.5	45.1	49.9	50.5	50.7	49.9	49.7	50.3	49.9
Individuals in female-headed families [2]	26.3	36.0	47.4	47.5	47.4	49.5	52.0	52.6	52.9	52.4
Individuals in all other families [2]	73.7	64.0	52.6	52.5	52.6	50.5	48.0	47.4	47.1	47.6
Blacks	25.1	31.1	29.2	28.2	27.8	27.0	29.8	29.8	29.5	29.5
Whites	72.1	67.7	68.7	68.4	68.1	69.1	65.8	65.6	65.3	65.9
Other races	2.8	1.2	2.1	3.4	4.1	3.9	4.4	4.7	5.3	4.6
Hispanic origin [3]	NA	NA	11.6	12.5	13.1	15.8	16.8	16.9	16.9	17.2
Individuals in families with children [4]	NA	NA	NA	NA	NA	NA	NA	NA	NA	67.9
Male present	NA	NA	NA	NA	NA	NA	NA	NA	NA	31.3
Female-headed	NA	NA	NA	NA	NA	NA	NA	NA	NA	36.6
Individuals in all other families	NA	NA	NA	NA	NA	NA	NA	NA	NA	32.1

[1] Data are for March of the following year.

[2] Includes unrelated or single individuals.

[3] Hispanic origin may be of any race; therefore numbers add to more than 100 percent.

[4] Family includes related children under 18.

NA—Not available.

Note: 1987 Revised, 1988, 1989 estimates are not comparable to prior years due to processing changes in the CPS.

Source: 1959–1985 Estimates based on data from "Money Income and Poverty Status of Families and Persons in the United States 1985," P-60 No. 154 and No. 157. 1986–1989 data from March 1990 Current Population Survey.

POVERTY RATES FOR FAMILIES [5]

Table 12 presents poverty data for families and unrelated individuals (individuals living alone). Female-headed families with children and unrelated individuals are more likely to be poor than other families with children or families with aged members. In 1989, 44 percent of female-headed families with children were poor, compared with 8 percent of male-present families. Although only about 7 percent of all families with an aged member were poor, 22 percent of all aged unrelated individuals were poor. About 18 percent of nonaged unrelated individuals were poor.

---

[5] Income figures reported in this subsection were from the March 1988 Current Population Survey (CPS) computer data tape. There is a tendency in surveys, such as the CPS, for respondents to underreport their incomes by both source and amount. Reporting of income from earnings is usually more accurate than reporting of income from other sources. In general, CPS estimates of amounts or numbers of recipients of various cash and noncash transfer programs tend to be lower than administrative program totals. As a result, the data are a better reflection of general trends and patterns than of absolute numbers with income from a particular source, or the amount received.

Unrelated subfamilies are included as families in this analysis. The Census Bureau excludes such families from its poverty counts.

TABLE 12.—POVERTY RATES BY FAMILY TYPE, 1982–89, AND PERCENTAGE OF FAMILIES AND UNRELATED INDIVIDUALS BY RATIO OF TOTAL INCOME TO POVERTY THRESHOLD, 1989 [1, 2]

	Poverty rate, 1982–89								Ratio of total income to poverty threshold, 1989							1989 total (in thousands)
	1982	1983	1985	1986	1987	1987 R	1988	1989	Under 0.50	0.50 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	
Total:																
Families	12.5	12.6	11.6	11.2	11.2	11.0	10.8	10.6	4.1	6.4	3.8	4.2	8.8	17.7	54.9	66,624
Unrelated individuals	23.1	23.4	21.4	21.6	20.8	20.4	20.6	19.2	7.3	12.0	7.3	6.4	11.2	18.1	37.8	35,185
No members age 65 or over:																
Families	13.3	13.5	12.7	12.3	12.1	11.9	11.6	11.5	4.7	6.8	3.6	3.8	8.0	16.9	56.2	54,103
Unrelated individuals	21.4	22.1	19.8	20.2	19.1	19.1	19.3	18.1	8.9	9.3	4.9	4.1	10.0	18.3	44.6	25,356
Any member age 65 or over:																
Families	9.0	8.8	7.1	6.8	7.1	7.2	6.9	6.6	1.5	5.0	4.7	5.9	12.1	21.2	49.5	12,521
Unrelated individuals	27.1	26.5	25.6	25.2	24.0	23.9	24.1	22.0	3.1	18.9	13.5	12.1	14.4	17.6	20.3	9,828
Families with children:																
Female headed family, no husband present	48.2	47.8	46.0	46.9	46.9	46.3	45.5	43.7	21.5	22.1	7.8	7.3	11.4	14.6	15.1	7,865
Male present families	10.2	10.5	9.3	8.5	8.3	8.1	7.7	8.0	2.3	5.7	3.8	4.1	9.6	21.4	53.2	26,903

[1] Based on census ("Orshansky") poverty levels.

[2] Unrelated subfamilies are treated as separate families; related subfamilies are not treated as separate families but as members of the family with whom they reside.

Note.—1987 Revised, 1988, 1989 estimates are not comparable to prior years due to processing changes in the CPS.

Source: March Current Population Survey for selected years. Table prepared by CRS.

INTERNATIONAL COMPARISONS OF THE POVERTY OF FAMILIES

Explanations of the methodology.—The income data used in this analysis to calculate poverty comes from the Luxembourg Income Study (LIS). The LIS data base includes nine countries.

Child poverty rates.[6]—Table 13 presents evidence on the trends in child poverty for five nations for various periods between 1979 and 1987, and the level of poverty for three additional nations at the beginning of the 1980s. Poverty is defined relative to the national median disposable income adjusted for family size in each country for each year. Table 13 uses a 40 percent of the median standard which is very close to the official poverty line of the United States. (The U.S. official poverty line was approximately 41 percent of median adjusted income in both 1979 and 1986.)

The United States has the highest overall poverty rate among children of all nations studied—more than twice the five country average rate in both periods. In 1986, 20.4 percent of all children were poor in the United States. The difference between the United States and the nearest nations at the time was about 11 percentage points. U.S. poverty rates of 20 percent compared with 9 percent rates in Canada and Australia and were 2.4 times the five country average rate of 8.5 percent. During the 1980s, the distance between the United States and other nations increased. Between 1979 and 1986, the U.S. child poverty rate increased by 4.8 percentage points while the overall child poverty rates actually decreased between 1981 and 1987 in Canada and Sweden, and faced little change in Australia.

U.S. children living with single parents also had the highest poverty rates (54.2) of all nations studied. While other nations experienced more rapid growth in single parents than did the United States, the gap between the U.S. rate and most other nations has not narrowed over this period.

Income distribution.[7]—The Luxembourg Income Study (LIS) data base also allows for direct microdata based comparisons of income distributions across countries. Table 14 measures income inequality for all individuals and the relative position of children (persons under 18) and elderly (persons age 65 and over) in the United States as compared to a number of other countries. The comparisons in table 14 use adjusted income which adjusts disposable family income for differences in family size using an adult equivalence scale. The poverty line is defined as equal to one half of the median adjusted income (or well-being) measure.

To examine the relative economic status of various types of families, the table breaks down the population into four income groupings:

1. Poor (adjusted incomes below 0.5 times median income);
2. Near poverty (adjusted incomes between 0.5 and 0.625 times median income);

---

[6] Smeeding, Timothy M. "Cross National Perspectives on Trends in Child Poverty and the Effectiveness of Government Policies in Preventing Poverty among Families with Children in the 1980's: The First Evidence from LIS." Unpublished manuscript.

[7] Smeeding, Timothy M. "Income Inequality: Cross-National and Comprehensive Perspectives." Statement prepared for the Joint Economic Committee, Congress of the United States, May 11, 1989.

TABLE 13.—LEVELS AND TRENDS IN RELATIVE POVERTY RATES,[1] AT 40 PERCENT ADJUSTED MEDIAN DISPOSABLE INCOME AMONG CHILDREN IN EIGHT WESTERN NATIONS DURING THE 1980'S[2]

Period I

	United States (1979)	Australia (1981)	Canada (1981)	West Germany[3] (1981)	Sweden[4] (1981)	United Kingdom (1979)	Netherlands (1983)	France (1979)	Average[5]
All children[6]	14.7	8.6	10.2	1.3	2.1	3.3	4.0	4.7	7.4
One-parent families[7]	46.1	33.6	39.9	3.3	3.7	10.9	1.5	11.9	25.3
Two-parent families[8]	7.2	6.5	7.2	0.6	1.8	3.0	0.7	3.4	4.7
Extended families[9]	13.7	3.6	5.3	3.5	NA	0.5	18.6	8.0	6.5

Period II

	United States (1986)	Australia (1985)	Canada (1987)	West Germany (1984)	Sweden (1987)	United Kingdom (1986)	Netherlands (1987)	France (1984)	Average
All children	20.4	9.0	9.3	2.8	0.8	NA	NA	NA	8.5
One-parent families	54.2	34.6	37.1	15.9	0.6	NA	NA	NA	28.5
Two-parent families	11.5	6.9	7.0	2.2	0.9	NA	NA	NA	5.7
Extended families	22.4	4.4	4.9	2.7	NA				8.6

TABLE 13.—LEVELS AND TRENDS IN RELATIVE POVERTY RATES,[1] AT 40 PERCENT ADJUSTED MEDIAN DISPOSABLE INCOME AMONG CHILDREN IN EIGHT WESTERN NATIONS DURING THE 1980'S [2]—Continued

Change [10]

	United States (1979)	Australia (1981)	Canada (1981)	West Germany (1981)	Sweden (1981)	United Kingdom (1979)	Netherlands (1983)	France (1979)	Average
All children	5.7	0.4	−0.9	1.5	−1.3	NA	NA	NA	1.1
One-parent families	8.1	1.0	−2.8	12.6	−3.1	NA	NA	NA	3.2
Two-parent families	4.3	0.4	−0.2	1.6	−0.9	NA	NA	NA	1.0
Extended families	8.7	0.8	−0.4	−0.8	NA	NA	NA	NA	2.1

[1] Poverty rates are the percent of children living in families with incomes below 40 percent of the adjusted median disposable income in each country.

[2] See text for a more complete explanation of each term.

[3] W. Germany (1981) and (1984) datasets are not strictly comparable.

[4] Sweden has no extended families because of their nuclear family income unit definition.

[5] Average is the simple average of the first five countries with entries in the table.

[6] All persons age 17 and under regardless of living arrangements.

[7] All persons age 17 and under living with one adult in the family household.

[8] All persons age 17 and under living with two adults, a married couple or two persons living as married and no other adults.

[9] Persons in all other living arrangements, including those with children over age 18.

[10] Change is defined as period II minus period I.

NA=Data not available.

Source: Smeeding, Timothy M. "Cross National Perspectives on Trends in Child Poverty and the Effectiveness of Government Policies in Preventing Poverty among Families with Children in the 1980's: The First Evidence from LIS." Unpublished manuscript.

TABLE 14.—DISTRIBUTION OF PERSONS BY ADJUSTED INCOME

[All persons]

	Poor	Near poor	Middle classs	Well-to-do
Country:				
United States	16.6	7.6	53.7	22.1
Australia	11.6	9.8	56.0	22.6
Canada	12.3	8.7	58.5	20.6
Netherlands	7.5	6.7	62.5	23.3
Switzerland	8.2	7.7	67.2	16.9
United Kingdom	11.7	9.7	58.5	20.2
Israel	11.0	10.6	54.2	24.2
Germany	4.9	7.7	70.1	17.3
Norway	4.8	8.4	73.4	13.4
Sweden	5.0	5.5	79.0	10.5
Average	9.4	8.2	63.3	19.1
Children:				
United States	21.4	9.0	57.1	12.6
Australia	15.4	8.6	64.4	11.6
Canada	15.2	9.1	64.4	11.3
Netherlands	8.0	10.5	68.8	12.8
Switzerland	7.3	8.4	74.8	9.5
United Kingdom	9.3	9.7	69.9	11.1
Israel	10.8	12.8	58.1	18.2
Germany	2.8	8.5	78.2	10.6
Norway	5.0	5.8	79.7	9.6
Sweden	5.2	4.6	83.3	7.0
Average	10.0	8.7	69.9	11.4
Elderly:				
United States	24.6	11.5	47.9	15.9
Australia	14.9	30.3	43.1	11.8
Canada	18.5	18.6	48.6	14.2
Netherlands	3.4	3.2	71.5	21.9
Switzerland	11.4	16.1	56.1	16.5
United Kingdom	34.7	21.7	36.8	6.9
Israel	25.0	14.3	45.0	15.7
Germany	11.8	13.6	59.6	15.0
Norway	5.5	24.7	60.1	9.7
Sweden	1.1	10.4	85.2	3.3
Average	15.1	16.4	55.4	13.1

Note: Each row adds to 100 percent. Poor are persons of each type living in families with incomes less than half (0.5) of median adjusted income. Near poor are those between 0.5 and 0.625 median adjusted income; middle-class from 0.625 to 1.5 the median adjusted income; and well-to-do above 1.5 of median adjusted income.

Source: Smeeding, Timothy M. "Income Inequality: Cross-National and Comprehensive Perspectives." Statement prepared for the Joint Economic Committee, Congress of the United States, May 11, 1989. LIS database.

3. Middle class (adjusted income between 0.626 and 1.5 times median income); and
4. Well-to-do (adjusted incomes above 1.5 times median income).

In table 14, each row adds to 100 percent, showing the simple mean (column average) of each set of estimates. The table shows that both children and elderly are more liable to be among the poor and are less likely to be among the well-to-do than the average person in society (top panel). The elderly are more likely to be found near the top and bottom of the distribution, especially among the near poor, than are children. In fact, there are more near-poor elderly than poor elderly. However, these percentages vary considerably across countries within each grouping.

When comparing the United States to other countries, table 14 shows that on an after-tax money income basis, the United States is the most unequal of the 10 modern nations studied. The newer countries (United States, Australia, and Canada) tend to have more poverty and fewer people who are middle class than do other countries, and the Scandinavian countries tend to have the least poverty and the largest middle class. However, the remaining ranking are not as clear cut. For instance, while the United States has the highest level of poverty among the countries studied, it is only fourth highest in the fraction of persons living in families which are well-to-do, ranking behind Israel, Netherlands, and Australia.

The bottom two panels show the distributions for children and elderly. Among persons living in families with children, the United States has by far the highest fraction living in poverty, over 21 percent, with the other two large countries (Australia and Canada) near 15 percent, and all European and Scandinavian countries with less than half as many children in poverty. The U.S. elderly tend to look more like other nations' elderly and are relatively less disadvantaged than U.S. children.

Duration of social assistance.[8]—Comparative income distribution data from the Luxembourg Income Study show large differences across countries in the incidence of poverty as well as differences within countries in poverty risks as they affect different demographic groups (as shown in table 13). However, these snapshot pictures tell us nothing about the dynamic nature of family economic mobility. A dynamic perspective on the distribution of family income shows that while the *incidence* of poverty is generally lower in Canada and Western European countries than in the United States, all countries share remarkably similar patterns of *economic mobility* that produce a mixture of long- and short-term poverty experiences.

A useful way of describing the nature of social assistance experiences is with data on the duration of completed spells (continuous periods of receipt observed from beginning to end.) Since most of the information on the length of spells from the survey and administrative record data were still in progress at the time of the data collection, the study used event-history methods to construct estimates of the duration of completed spells.

The data show very different patterns of social-assistance receipt across countries. Receipt tends to be relatively short-term in the

---

[8] Duncan, Greg J., Bjorn Gustafsson, Richard Hauser, Pierre Hausman, Stephen Jenkins, Hans Messinger, Ruud Muffels, Brian Nolan, Jean-Claude Ray, Willard Rogers, and Wolfgang Voges. "Poverty and Social Assistance Dynamics in Eight Countries." Unpublished manuscript, December 19, 1990.

United States and Germany, somewhat longer-term in Canada and much longer-term in the United Kingdom (chart 2). The proportion of lone-parents still receiving social assistance after 4 years was roughly 40 percent in the United States, 50 percent in Germany, 60 percent in Canada and 85 percent in the United Kingdom. After 5 years, these proportions fell to 38 and 35 percent in Germany and the United States, but remained at a fairly high level—83 percent—in the United Kingdom. (Duration data beyond 4 years are not yet available.) Within countries, social-assistance spells involving lone-parent families were substantially longer than spells involving two-parent families.

Effect of government programs on the extent and depth of poverty.[9]—Tables 15 and 16 examine the impact of government direct tax and transfer programs during the 1980s on poverty, as measured by the poverty rate, and on the depth of poverty, as measured by the poverty gap. The poverty gap is expressed as a percentage of the poverty line in each country. The effect of government programs are measured by comparing poverty rates and gaps based on pretax and transfer (market) income to those based on posttax and transfer (disposable) income. The net effect of taxes and transfers cannot be directly separated because most nations subject their transfer payments to income taxation.

Table 15 shows the effects of government programs on overall child poverty. The table has two panels: the top panel reflects the change in the poverty rate and the bottom panel indicates the change in the poverty gap. Both measures use the 40 percent standard (as explained above).

The net effect of U.S. Government tax and transfer programs on overall poverty rates among families with children was the least among the countries studied. On average, the tax and transfer systems of the eight countries reduced child poverty by 3.2 points during the first period and 5.1 points during the second period. Thus, on average, the effectiveness of these nations' tax and transfer systems in reducing poverty increased over time. In contrast, the U.S. system reduced child poverty rates by 4.3 percent in 1979, but fell to only 1.9 points in 1986. Additionally, pretax and transfer poverty increased in almost all nations over the period studied, but posttax and transfer poverty increased by a large amount only in the United States and in West Germany.

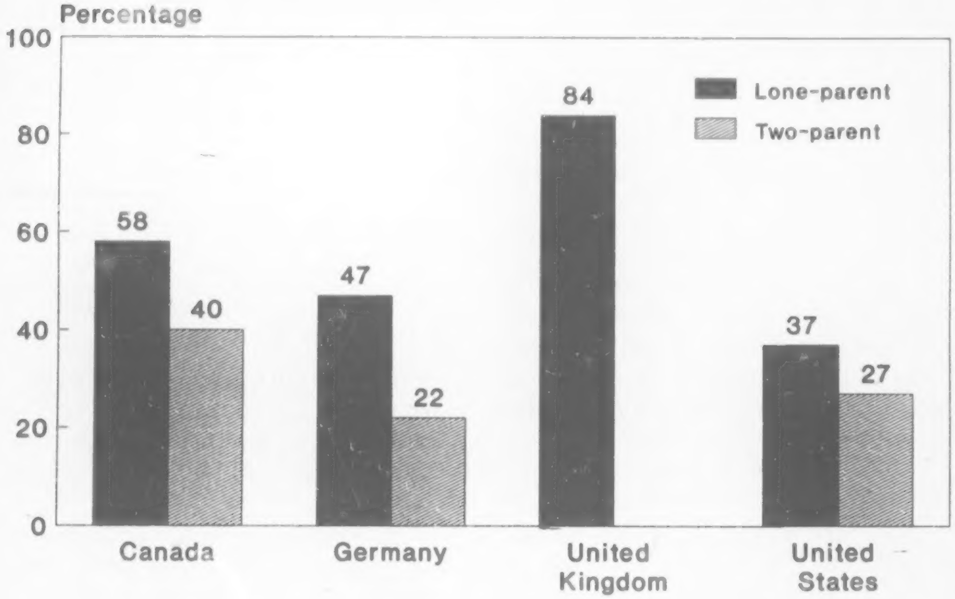
There is much more similarity between the United States and other nations in the level and trend of poverty gaps across nations and over time. While the U.S. pretax and transfer gaps remained at about 65 percent, the net effect of government on the poverty gap increased over this period, reducing the posttax and transfer gap by about 4 percentage points to nearly the average of the other nations. Canadian and German systems also reduced their posttax and transfer gaps over this period, while Australian and Swedish gaps widened.

Table 16 shows the effects of government programs on child poverty in single-parent families. Overall, the U.S. tax and transfer system is the least effective in reducing child poverty in single-parent families. In 1979, the U.S. tax and transfer system reduced poverty among children in single-parent families by 8.1 percentage points; by 1986, the effect had decreased to 1.0 points. The average reduction among all five nations was 18 percentage points in the second period.

---

[9] Smeeding, Timothy M. "Cross National Perspectives on Trends in Child Poverty and the Effectiveness of Government Policies in Preventing Poverty among Families with Children in the 1989's: The First Evidence from LIS." Unpublished manuscript.

CHART 2. PERCENT OF SOCIAL ASSISTANCE SPELLS LASTING AT LEAST 4 YEARS, BY FAMILY STRUCTURE, IN FOUR SELECTED COUNTRIES



Source: Duncan, Greg J., Bjorn Gustafsson, Richard Hauser, Pierre Hausman, Stephen Jenkins, Hans Messinger, Ruud Muffels, Brian Nolan, Jean-Claude Ray, Willard Rogers, and Wolfgang Voges. "Poverty and Social Assistance Dynamics in Eight Countries." Unpublished manuscript, December 19, 1990.

TABLE 15.—CHANGES IN THE EFFECT OF TAX AND TRANSFER ON THE EXTENT AND DEPTH OF POVERTY AMONG CHILDREN IN EIGHT WESTERN NATIONS DURING THE 1980'S [1]

[Poverty Rates at 40 Percent of the Median [2]]

	United States	Australia	Canada	West Germany [3]	Sweden	United Kingdom	Netherlands	France	Average [4]
Period I	1979	1981	1981	1981	1981	1979	1983	1979	
Pretax and transfer	19.0	15.9	15.5	3.6	8.2	10.5	15.2	18.7	12.4
Posttax and transfer	14.7	8.6	10.2	1.3	2.1	3.3	4.0	4.7	7.4
Net effect [5]	4.3	7.3	5.3	2.3	6.1	7.2	11.2	14.0	5.1
Period II	1986	1985	1987	1984	1987				
Pretax and transfer	22.3	16.4	15.7	8.4	7.7	NA	NA	NA	14.1
Posttax and transfer	20.4	9.0	9.3	2.8	0.8	NA	NA	NA	8.5
Net effect	1.9	7.4	6.4	5.6	6.9	NA	NA	NA	5.7
Change [6]									
Pretax and transfer	3.3	0.5	0.2	4.8	−0.5	NA	NA	NA	1.9
Posttax and transfer	5.7	0.4	−0.9	1.5	−1.3	NA	NA	NA	1.1

[1] See text for a more complete explanation of each term.

[2] Poverty rates are the percent of children living in families with incomes below half of the 40 percent median disposable income in each country. Two concepts of income are used: pre-tax and transfer income and post-tax and transfer (or disposable) income.

[3] W. Germany (1981) and (1984) datasets are not strictly comparable.

[4] Average is the simple average of the first five countries with entries in the table.

[5] Net effect of government is "Pre" minus "Post."

[6] Change is defined as Period II minus Period I.

TABLE 15.—CHANGES IN THE EFFECT OF TAX AND TRANSFER ON THE EXTENT AND DEPTH OF POVERTY AMONG CHILDREN IN EIGHT WESTERN NATIONS DURING THE 1980'S [1]—Continued

[Poverty Gap as a Percent of Poverty Line at 40 Percent of the Median [7]]

	United States	Australia	Canada	West Germany [3]	Sweden	United Kingdom	Netherlands	France	Average
Period I	1979	1981	1981	1981	1981	1979	1983	1979	
Pretax and transfer	65.1	76.1	59.8	66.5	58.0	64.9	90.7	44.7	65.1
Posttax and transfer	39.3	39.5	32.1	34.6	36.5	19.9	75.3	36.0	36.4
Net effect	25.8	36.6	27.7	31.9	21.5	45.0	15.4	8.7	28.7
Period II	1986	1985	1987	1984	1987				
Pretax and transfer	65.5	76.8	62.7	68.9	49.1	NA	NA	NA	64.6
Posttax and transfer	35.3	41.9	28.1	23.8	43.4	NA	NA	NA	34.5
Net effect	30.2	34.9	34.6	45.1	5.7	NA	NA	NA	30.1
Change									
Pretax and transfer	0.4	0.7	2.9	2.4	−8.9	NA	NA	NA	−0.5
Posttax and transfer	−4.0	2.4	−4.0	−10.8	6.9	NA	NA	NA	−2.0

---

[7] The poverty gap is the mean difference between the 40 percent median povery line and adjusted income of the poor expressed as a percent of the poverty line for both pre-tax and transfer income and post-tax and transfer income.

NA=Data not available.

Source: Smeeding, Timothy M. "Cross National Perspectives on Trends in Child Poverty and the Effectiveness of Government Policies in Preventing Poverty among Families with Children in the 1980's: The First Evidence from LIS." Unpublished manuscript.

TABLE 16.—CHANGES IN THE EFFECT OF TAX AND TRANSFER ON THE EXTENT AND DEPTH OF POVERTY AMONG CHILDREN LIVING IN SINGLE-PARENT FAMILIES IN EIGHT WESTERN NATIONS DURING THE 1980's[1]

[Poverty Rates at 40 Percent of the Median [2]]

	United States	Australia	Canada	West Germany [3]	Sweden	United Kingdom	Netherlands	France	Average [4]
Period I									
	1979	1981	1981	1981	1981	1979	1983	1979	
Pretax and transfer	54.2	60.2	47.6	21.9	28.6	39.9	69.4	42.1	42.5
Posttax and transfer	46.1	33.6	39.9	3.3	3.7	10.9	1.5	11.9	25.3
Net effect [5]	8.1	26.6	7.7	18.6	24.9	29.0	67.9	30.2	17.2
Period II	1986	1985	1987	1984	1987				
Pretax and transfer	55.2	59.9	51.5	43.0	22.8	NA	NA	NA	46.5
Posttax and transfer	54.2	34.6	37.1	15.9	0.6	NA	NA	NA	28.5
Net effect	1.0	25.3	14.4	27.1	22.2	NA	NA	NA	18.0
Change [6]	1979–86	1981–85	1981–87	1981–84	1981–87				
Pretax and transfer	1.0	−0.3	3.9	21.1	−5.8	NA	NA	NA	4.0
Posttax and transfer	−8.1	1.0	−2.8	12.6	−3.1	NA	NA	NA	3.2

[Poverty Gap as a Percent of Poverty Line at 40 Percent of the Median [7]]

	United States	Australia	Canada	West Germany	Sweden	United Kingdom	Netherlands	France	Average
Period I	1979	1981	1981	1981	1981	1979	1983	1979	
Pretax and transfer	75.5	84.9	75.4	80.5	68.0	78.5	94.2	59.8	76.9
Posttax and transfer	41.3	34.1	33.5	29.5	46.6	16.2	4.6	37.2	37.0
Net effect	34.2	50.8	41.9	51.0	21.4	62.3	89.6	22.6	37.9
Period II	1986	1985	1987	1984	1987				
Pretax and transfer	77.0	87.1	76.3	81.3	45.6	NA	NA	NA	73.5
Posttax and transfer	36.2	29.0	23.9	29.7	18.5	NA	NA	NA	27.5
Net effect	40.8	58.1	52.4	51.6	27.1	NA	NA	NA	46.0
Change	1979–86	1981–85	1981–87	1981–84	1981–87				
Pretax and transfer	1.5	2.2	0.9	0.8	−22.4	NA	NA	NA	−3.4
Posttax and transfer	−5.1	−5.1	−9.6	0.2	−28.1	NA	NA	NA	−9.5

[1] See text for a more complete explanation of each term.

[2] Poverty rates are the percent of children living in families with incomes below half of the 40 percent median disposable income in each country. Two concepts of income are used: pre-tax and transfer income and post-tax and transfer (or disposable) income.

[3] W. Germany (1981) and (1984) datasets are not strictly comparable.

[4] Average is the simple average of the first five countries with entries in the table.

[5] Net effect of government is "Pre" minus "Post."

[6] Change is defined as Period II minus Period I.

[7] The poverty gap is the mean difference between the 40 percent median poverty line and adjusted income of the poor expressed as a percent of the poverty line for both pre-tax and transfer income and post-tax and transfer income.

NA=Data not available.

Source: Smeeding, Timothy M. "Cross National Perspectives on Trends in Child Poverty and the Effectiveness of Government Policies in Preventing Poverty among Families with Children in the 1980's: The First Evidence from LIS." Unpublished manuscript.

ANTIPOVERTY EFFECTIVENESS OF VARIOUS CASH, NEAR-CASH AND NONCASH INCOME SOURCES

Methodology

As shown earlier in Appendix G and Appendix H, families and individuals differ markedly by the combinations of income upon which they rely for support. This section explores the effectiveness of various income sources in addressing poverty.

One way of assessing the antipoverty effectiveness of various income sources is to estimate the number of persons who would be counted as poor if a particular source of income were not received. The additional number of persons that are counted as poor provides an estimate of the number of people lifted out of poverty by a particular income source. For example, the effect of Social Security upon poverty can be seen by comparing the number who would be counted as poor if they did not receive Social Security with the number of poor remaining after Social Security income is counted.

A second way of assessing the effectiveness of various income sources upon poverty is to estimate the degree to which those sources reduce the gap between a poor family's income and the poverty threshold. This concept is sometimes known as the "poverty gap" or the "poverty income deficit." A cash transfer program which is highly targeted on the poor may do little to eliminate poverty—that is, to reduce the number who are counted as poor—but such a program may still have a very real impact by reducing the degree of poverty as viewed in terms of the poverty gap.

Tables 17 through 21 examine the antipoverty effectiveness of cash and noncash transfers from 1979 to 1989. These tables were prepared by the Congressional Budget Office using Census Bureau data and present information for all individuals in various types of living arrangements.

All statistics are based on Current Population Survey (CPS) data for the relevant year, unadjusted for possible underreporting. However, asset income data have been adjusted for 1979 through 1983 to make them comparable to data for more recent years. This adjustment involved applying a more detailed methodology to impute asset income to people who reported receiving asset income but did not report the amount received. The effect of the changes is to increase incomes, particularly for the elderly. For the entire population, the poverty rate is reduced by about 0.1 percentage point in each year, 1979 through 1983. It was not possible, however, to adjust the data from earlier years to reflect the other change made in 1984—the revised weighting of persons of Hispanic origin.

Federal personal income taxes and Social Security payroll taxes were estimated with a microsimulation model using tax schedules and laws in effect in each year. In order to make taxes consistent with the incomes reported in the CPS, no adjustments were made for CPS underreporting and taxes were not estimated for capital gains or other taxable income not reported in the CPS. Statistics of Income (SOI) data were used to assign itemized deductions and Individual Retirement Account (IRA) contributions to tax filing units, while child care expenses were estimated based on data from the 1979 Panel Study of Income Dynamics (PSID). Payroll tax estimates were based on self-employment income and wages and salaries of all workers except Federal, railroad, and some state employees.

All valuations of in-kind transfers are those estimated by the Bureau of the Census using a *market value* valuation technique.[10] The market value generally attempts to measure the private market cost of benefits provided in-kind. Food stamps are assigned their value, while school lunches are assigned the average amount of Federal subsidy per child. Housing assistance is valued as the difference between the estimated market rent (based on the American Housing Survey) and the reduced rent paid by subsidized households.

Poverty under six different income concepts is measured. "Cash income before transfers" is all cash income prior to any benefits from government programs. This would include all earnings, pension income, income from savings, self-employment income, etc. "Plus social insurance" adds to cash income all benefits from social insurance (except Social Security) programs, such as workers' compensation and unemployment compensation. "Plus Social Security" adds to cash income and social insurance income benefits from the Social Security programs. "Plus means-tested cash transfers" adds to cash income and social insurance income all means-tested transfer income such as aid to families with dependent children, supplemental security income, and general assistance. "Plus food and housing" adds to cash, social insurance and means-tested cash income all means-tested in-kind transfers received for food and housing. This would include food stamps, housing programs and school lunch programs. Benefits are valued using the *market value* method. "Less Federal taxes" subtracts from income Federal income taxes and the employee portion of Federal payroll taxes.

Results

Table 17 shows that before any governmental transfers, 49.1 million individuals would have been poor in 1989. With social insurance benefits (including Social Security), 33.8 million individuals are poor, a reduction of 15.2 million. Means-tested cash and in-kind transfers reduce the poverty count by an additional 6.2 million individuals.

In 1979, 15.0 percent of all poor individuals were removed from poverty due to means-tested transfers and Federal tax policy. In 1983, this had declined to 5.7 percent. Beginning in 1984, the downward trend reversed itself and the percentage increased to 6.6 percent in 1986. By 1989, largely due to the effect of the 1986 Tax Reform Act, which reduced tax liability for low-income families, the percentage increased even further to 10.0 percent.

Tables 18, 19, and 20 display the effectiveness of social insurance and means-tested programs in eliminating poverty among individuals in families with children. Table 18 presents information on individuals in all families with children under 18 years old; table 19 presents information on individuals in families that are headed by an unmarried individual and have children under 18 years old; and table 20 presents information on individuals in married-couple families with children under 18 years old. Table 19 shows that in 1979 approximately 30 percent of individuals in single-parent families were removed from poverty as the result of means-tested transfers, food and housing benefits, and Federal tax policy. By 1989, this had declined to 17 percent. Similarly, the percentage reduction in the poverty gap due to means-tested transfers and Federal tax policy fell from 56 percent to 51 percent.

---

[10] See Bureau of the Census, "Alternative Methods for Valuing Selected In-Kind Transfer Benefits and Measuring Their Effect on Poverty," Technical Paper 50, March 1982, for a discussion of the estimation methods. Technical papers 51, 52, 55, and 56 provide data for all years from 1979 through 1985.

Table 21 displays the effectiveness of social insurance and means-tested transfer programs in eliminating poverty among the elderly over the 1979–1989 period. The table shows that over this period the antipoverty effectiveness of both social insurance and means-tested programs generally improved for the elderly: despite a significant increase in the overall elderly population, the number of individuals in poverty actually declined, and the poverty gap remained fairly level. The numbers of individuals removed from poverty by social insurance programs increased from 7.1 to 8.8 million between 1979 and 1989. The percentage of elderly individuals removed from poverty due to social insurance programs increased from 68 percent to 74 percent from 1979 to 1989. The number removed from poverty by means-tested transfer programs increased from 716,000 to 803,000 over the same period.

Chart 3 below is based upon table 18. The chart illustrates the effects means-tested benefits and Federal taxes have on removing individuals living in families with children from poverty, for each year from 1979 to 1989. The top line shows the number of individuals removed from poverty due to means-tested benefits. The bottom line illustrates the number of individuals added back into poverty after means-tested benefits and Federal income and payroll taxes. The difference between those lines (the middle line) for a given year represents the total number of individuals removed from poverty after means-tested benefits have been received and Federal taxes have been paid. For example, in 1989, the total number removed from poverty due to means-tested cash, food and housing benefits was 4.3 million. Federal taxes added 714,000 of those individuals back into poverty, leaving the net number removed from poverty at 3.5 million.

CHART 3. EFFECTS OF MEANS-TESTED PROGRAMS AND TAXES ON INDIVIDUALS IN POVERTY, 1979–1989

Number of Individuals Living in Families With Children

CHART 3. EFFECTS OF MEANS-TESTED PROGRAMS AND TAXES ON FAMILIES IN POVERTY, 1979–1989

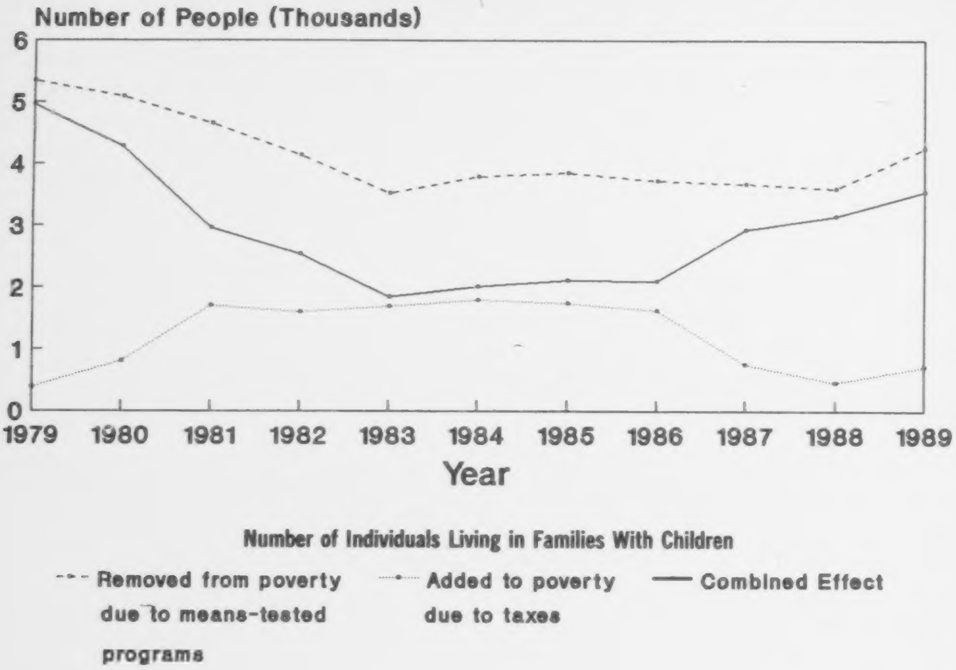


TABLE 17.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR ALL INDIVIDUALS IN FAMILIES OR LIVING ALONE, 1979–89

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Number of poor individuals (thousands):											
Cash income before transfers	41,695	46,273	49,184	51,942	52,700	50,943	50,462	49,702	49,679	49,145	49,052
Plus social insurance (other than Social Security)	39,835	44,016	46,974	48,989	49,468	48,690	48,208	47,466	47,731	47,297	47,377
Plus Social Security	27,846	31,638	33,909	36,204	36,928	35,702	35,171	34,534	34,380	33,850	33,825
Plus means-tested cash transfers (official definition)	25,201	29,114	31,567	34,200	35,030	33,700	33,064	32,370	32,546	31,745	31,534
Plus food and housing benefits	20,931	24,882	27,703	30,493	31,697	30,103	29,489	28,988	29,004	28,357	27,642
Less Federal taxes	21,606	26,030	29,983	32,549	33,923	32,529	31,840	31,249	30,400	29,214	28,941
Number of individuals removed from poverty due to (thousands):											
Social insurance (other than Social Security)	1,860	2,257	2,210	2,953	3,232	2,253	2,254	2,236	1,948	1,848	1,675
Social insurance (including Social Security)	13,849	14,635	15,275	15,738	15,772	15,241	15,291	15,168	15,299	15,295	15,227
Means-tested cash, food, and housing benefits	6,915	6,756	6,206	5,711	5,231	5,599	5,682	5,546	5,376	5,493	6,183
Federal taxes	−675	−1,148	−2,280	−2,056	−2,226	−2,426	−2,351	−2,261	−1,396	−857	−1,299
Percent of individuals removed from poverty due to:											
Social insurance (including Social Security)	33.2	31.6	31.1	30.3	29.9	29.9	30.3	30.5	30.8	31.1	31.0
Means-tested cash, food and housing benefits and Federal taxes	15.0	12.1	8.0	7.0	5.7	6.2	6.6	6.6	8.0	9.4	10.0
Poverty gap (millions of 1987 dollars):											
Cash income before transfers	100,276	111,613	118,235	123,562	126,720	122,517	122,327	122,905	124,246	121,956	120,028

TABLE 17.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR ALL INDIVIDUALS IN FAMILIES OR LIVING ALONE, 1979–89—Continued

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Plus social insurance (other than Social Security)	93,481	103,424	110,471	114,739	116,617	114,939	115,427	116,299	117,820	116,403	114,336
Plus Social Security	51,881	58,398	63,763	68,480	71,431	69,047	68,280	68,678	69,419	67,000	65,933
Plus means-tested cash transfers (official definition)	35,981	41,415	46,782	51,287	53,231	50,671	50,480	50,987	51,650	50,184	49,192
Plus food and housing benefits	28,176	32,239	37,441	40,687	42,409	40,021	39,929	40,316	40,434	38,962	38,059
Less Federal taxes	28,628	32,945	38,734	42,119	43,988	41,747	41,601	41,948	41,394	39,772	38,853
Percentage reduction in poverty gap due to:											
Social insurance (including Social Security)	48.3	47.7	46.1	44.6	43.6	43.6	44.2	44.1	44.1	45.1	45.1
Means-tested cash, food and housing benefits and Federal taxes	23.2	22.8	22.8	21.3	21.7	22.3	21.8	21.7	22.6	22.3	22.6
Poverty rate (in percent):											
Cash income before transfers	19.1	20.6	21.7	22.6	22.8	21.8	21.3	20.8	20.6	20.2	19.9
Plus social insurance (other than Social Security)	18.3	19.6	20.7	21.4	21.4	20.8	20.4	19.9	19.8	19.4	19.3
Plus Social Security	12.8	14.1	14.9	15.8	15.9	15.3	14.9	14.5	14.3	13.9	13.8
Plus means-test cash transfers (official definition)	11.6	12.9	13.9	14.9	15.1	14.4	14.0	13.6	13.5	13.0	12.8
Plus food and housing benefits	9.6	11.1	12.2	13.3	13.7	12.9	12.5	12.2	12.0	11.6	11.2
Less Federal taxes	9.9	11.6	13.2	14.2	14.6	13.9	13.5	13.1	12.6	12.0	11.8

Source: Congressional Budget Office and Committee staff.

Number of poor individuals (thousands):											
Cash income before transfers	21,510	24,795	26,446	28,759	28,935	27,277	26,639	26,121	25,735	25,305	25,190
Plus social insurance (other than Social Security)	20,559	23,518	25,204	26,895	26,948	26,010	25,368	24,824	24,689	24,257	24,341
Plus Social Security	18,599	21,544	23,111	25,036	25,255	24,408	23,701	23,292	23,222	22,504	22,704
Plus means-tested cash transfers (official definition)	16,808	19,902	21,553	23,796	24,246	23,301	22,547	22,111	22,157	21,299	21,408
Plus food and housing benefits	13,261	16,463	18,465	20,903	21,736	20,616	19,847	19,572	19,548	18,901	18,449
Less Federal taxes	13,638	17,370	20,159	22,503	23,420	22,405	21,586	21,199	20,295	19,352	19,163
Number of individuals removed from poverty due to (thousands):											
Social insurance (other than Social Security)	951	1,277	1,242	1,864	1,987	1,267	1,271	1,297	1,046	1,048	849
Social insurance (including Social Security)	2,911	3,251	3,335	3,723	3,680	2,869	2,938	2,829	2,513	2,801	2,486
Means-tested cash, food, and housing benefits	5,338	5,081	4,646	4,133	3,519	3,792	3,854	3,720	3,674	3,603	4,255
Federal taxes	−377	−807	−1,694	−1,600	−1,684	−1,789	−1,739	−1,627	−747	−451	−714
Percent of individuals removed from poverty due to:											
Social insurance (including Social Security)	13.5	13.1	12.6	12.9	12.7	10.5	11.0	10.8	9.8	11.1	9.9
Means-tested cash, food and housing benefits and Federal taxes	23.1	17.2	11.2	8.8	6.3	7.3	7.9	8.0	11.4	12.5	14.1
Poverty gap (millions of 1987 dollars):											
Cash income before transfers	37,976	44,120	46,721	51,466	52,785	49,614	48,558	48,472	48,668	47,063	45,501

TABLE 18.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR ALL INDIVIDUALS IN FAMILIES WITH RELATED CHILDREN LESS THAN 18, 1979–89

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Plus social insurance (other than Social Security)	35,801	40,886	43,606	47,604	48,349	46,705	46,090	45,998	46,643	44,945	43,431
Plus Social Security	30,505	35,446	37,860	42,230	43,154	41,741	40,861	41,006	41,643	39,672	38,404
Plus means-tested cash transfers (official definition)	19,610	23,545	26,114	30,135	30,612	29,339	28,633	28,609	29,325	28,343	27,288
Plus food and housing benefits	13,208	15,949	18,535	21,296	21,603	20,564	19,874	19,782	20,042	19,182	18,315
Less Federal taxes	13,202	16,090	19,068	21,953	22,353	21,397	20,611	20,471	20,121	19,109	18,263
Percentage reduction in poverty gap due to:											
Social insurance (including Social Security)	19.7	19.7	19.0	17.9	18.2	15.9	15.9	15.4	14.4	15.7	15.6
Means-tested cash, food and housing benefits and Federal taxes	45.6	43.9	40.2	39.4	39.4	41.0	41.7	42.4	44.2	43.7	44.3
Poverty rate (in percent):											
Cash income before transfers	16.5	18.6	20.0	21.7	21.9	20.7	20.0	19.5	19.2	18.8	18.6
Plus social insurance (other than Social Security)	15.8	17.6	19.0	20.3	20.4	19.7	19.0	18.5	18.4	18.0	18.0
Plus Social Security	14.3	16.1	17.4	18.9	19.2	18.5	17.8	17.4	17.3	16.7	16.8
Plus means-tested cash transfers (official definition)	12.9	14.9	16.3	17.9	18.4	17.6	16.9	16.5	16.5	15.8	15.8
Plus food and housing benefits	10.2	12.3	13.9	15.7	16.5	15.6	14.9	14.6	14.6	14.0	13.6
Less Federal taxes	10.5	12.9	15.2	17.0	17.8	17.0	16.2	15.8	15.1	14.4	14.2

Source: Congressional Budget Office and Committee staff.

TABLE 19.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR INDIVIDUALS IN ALL UNITS WITH AN UNMARRIED HEAD AND RELATED CHILDREN LESS THAN 18, 1979–89

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Number of poor individuals (thousands):											
Cash income before transfers	11,480	12,458	12,915	13,594	13,751	13,774	13,685	14,069	14,259	14,149	14,074
Plus social insurance (other than Social Security)	11,271	12,207	12,689	13,284	13,501	13,513	13,391	13,790	14,040	13,928	13,820
Plus Social Security	10,367	11,201	11,858	12,579	12,611	12,786	12,581	13,143	13,306	13,167	13,040
Plus means-tested cash transfers (official definition)	9,230	10,362	10,987	11,903	12,063	12,132	11,943	12,487	12,661	12,514	12,388
Plus food and housing benefits	6,901	8,363	9,191	10,312	10,531	10,473	10,418	10,879	10,963	10,947	10,636
Less Federal taxes	6,925	8,433	9,423	10,611	10,800	10,695	10,670	11,217	10,977	10,923	10,648
Number of individuals removed from poverty due to (thousands):											
Social insurance (other than Social Security)	209	251	226	310	250	261	294	279	219	221	254
Social insurance (including Social Security)	1,113	1,257	1,057	1,015	1,140	988	1,104	926	953	982	1,034
Means-tested cash, food and housing benefits	3,466	2,838	2,667	2,267	2,080	2,313	2,163	2,264	2,343	2,220	2,404
Federal taxes	−24	−70	−232	−299	−269	−222	−252	−338	−14	24	−12
Percent of individuals removed from poverty due to:											
Social insurance (including Social Security)	9.7	10.1	8.2	7.5	8.3	7.2	8.1	6.6	6.7	6.9	7.3
Means-tested cash, food and housing benefits and Federal taxes	30.0	22.2	18.9	14.5	13.2	15.2	14.0	13.7	16.3	15.9	17.0
Poverty gap (millions of 1987 dollars):											
Cash income before transfers	24,431	26,996	28,350	30,452	31,519	30,680	30,722	31,942	32,661	32,142	31,018

TABLE 19.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR INDIVIDUALS IN ALL UNITS WITH AN UNMARRIED HEAD AND RELATED CHILDREN LESS THAN 18, 1979–89 —Continued

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Plus social insurance (other than Social Security)	23,742	26,050	27,550	29,463	30,358	29,687	29,822	31,216	31,975	31,627	30,349
Plus Social Security	20,952	23,010	24,657	26,597	27,361	27,046	26,790	28,518	29,172	28,632	27,533
Plus means-tested cash transfers (official definition)	12,014	13,785	15,448	17,309	17,976	17,580	17,562	18,815	19,358	19,481	18,844
Plus food and housing benefits	7,446	8,406	9,960	11,073	11,682	11,341	11,181	12,119	12,304	12,401	12,003
Less Federal taxes	7,392	8,384	10,008	11,157	11,756	11,440	11,263	12,221	12,175	12,282	11,861
Percentage reduction in poverty gap due to:											
Social insurance (including Social Security)	14.2	14.8	13.0	12.7	13.2	11.8	12.8	10.7	10.7	10.9	11.2
Means-tested cash, food and housing benefits and Federal taxes	55.5	54.2	51.7	50.7	49.5	50.9	50.5	51.0	52.0	50.9	50.5
Poverty rate (in percent):											
Cash income before transfers	50.0	51.6	52.1	54.5	53.8	51.5	50.7	51.4	50.9	49.5	48.1
Plus social insurance (other than Social Security)	49.1	50.6	51.2	53.2	52.8	50.5	49.6	50.3	50.1	48.7	47.2
Plus Social Security	45.1	46.4	47.8	50.4	49.3	47.8	46.6	48.0	47.5	46.0	44.6
Plus means-tested cash transfers (official definition)	40.2	43.0	44.3	47.7	47.2	45.3	44.3	45.6	45.2	43.7	42.3
Plus food and housing benefits	30.0	34.7	37.1	41.3	41.2	39.1	38.6	39.7	39.1	38.3	36.4
Less Federal taxes	30.1	35.0	38.0	42.5	42.2	40.0	39.6	40.9	39.2	38.2	36.4

Source: Congressional Budget Office and Committee staff.

Plus social insurance (other than Social Security)	9,288	11,311	12,515	13,611	13,447	12,497	11,977	11,034	10,649	10,329	10,521
Plus Social Security	8,232	10,343	11,253	12,457	12,644	11,622	11,120	10,149	9,916	9,338	9,665
Plus means-tested cash transfers (official definition)	7,578	9,540	10,566	11,893	12,183	11,169	10,604	9,624	9,496	8,785	9,019
Plus food and housing benefits	6,360	8,100	9,274	10,591	11,205	10,143	9,429	8,693	8,585	7,953	7,813
Less Federal taxes	6,713	8,937	10,736	11,892	12,620	11,710	10,916	9,982	9,318	8,429	8,515
Number of individuals removed from poverty due to (thousands):											
Social insurance (other than Social Security)	742	1,026	1,016	1,554	1,737	1,006	977	1,018	828	827	596
Social insurance (including Social Security)	1,798	1,994	2,278	2,708	2,540	1,881	1,834	1,903	1,561	1,818	1,452
Means-tested cash, food and housing benefits	1,872	2,243	1,979	1,866	1,439	1,479	1,691	1,456	1,331	1,385	1,852
Federal taxes	−353	−837	−1,462	−1,301	−1,415	−1,567	−1,487	−1,289	−733	−476	−702
Percent of individuals removed from poverty due to:											
Social insurance (including Social Security)	17.9	16.2	16.8	17.9	16.7	13.9	14.2	15.8	13.6	16.3	13.1
Means-tested cash, food and housing benefits and Federal taxes	15.1	11.4	3.8	3.7	0.2	−0.7	1.6	1.4	5.2	8.1	10.3
Poverty gap (millions of 1987 dollars):											
Cash income before transfers	13,546	17,123	18,371	21,014	21,266	18,934	17,837	16,530	16,007	14,921	14,484

TABLE 20.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR ALL INDIVIDUALS IN MARRIED-COUPLE FAMILIES WITH RELATED CHILDREN LESS THAN 18, 1979–89—Continued

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Plus social insurance (other than Social Security)	12,059	14,836	16,057	18,141	17,991	17,019	16,268	14,782	14,668	13,318	13,082
Plus Social Security	9,554	12,436	13,204	15,632	15,794	14,695	14,072	12,488	12,471	11,039	10,871
Plus means-tested cash transfers (official definition)	7,596	9,759	10,665	12,826	12,636	11,759	11,071	9,794	9,967	8,862	8,443
Plus food and housing benefits	5,762	7,543	8,575	10,223	9,921	9,223	8,693	7,662	7,738	6,781	6,312
Less Federal taxes	5,809	7,707	9,060	10,795	10,597	9,957	9,348	8,251	7,946	6,827	6,402
Percentage reduction in poverty gap due to:											
Social insurance (including Social Security)	29.5	27.4	28.1	25.6	25.7	22.4	21.1	24.5	22.1	26.0	24.9
Means-tested cash, food and housing benefits and Federal taxes	27.6	27.6	22.6	23.0	24.4	25.0	26.5	25.6	28.3	28.2	30.9
Poverty rate (in percent):											
Cash income before transfers	9.4	11.2	12.6	14.1	14.3	12.8	12.2	11.3	10.8	10.5	10.5
Plus social insurance (other than Social Security)	8.7	10.3	11.6	12.6	12.7	11.9	11.3	10.4	10.0	9.7	9.9
Plus Social Security	7.7	9.4	10.4	11.6	11.9	11.0	10.5	9.5	9.4	8.8	9.1
Plus means-tested cash transfers (official definition)	7.1	8.7	9.8	11.0	11.5	10.6	10.0	9.0	9.0	8.3	8.5
Plus food and housing benefits	5.9	7.4	8.6	9.8	10.5	9.6	8.9	8.2	8.1	7.5	7.4
Less Federal taxes	6.3	8.1	10.0	11.0	11.9	11.1	10.3	9.4	8.8	7.9	8.0

Source: Congressional Budget Office and Committee staff.

TABLE 21.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR INDIVIDUALS IN UNITS WITH ALL MEMBERS 65 OR OLDER, 1979–89

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Number of poor individuals (thousands):											
Cash income before transfers	10,385	10,821	10,884	10,772	10,843	11,009	11,200	11,550	11,741	11,797	11,971
Plus social insurance (other than Social Security)	10,165	10,650	10,763	10,604	10,654	10,862	11,033	11,334	11,546	11,645	11,806
Plus Social Security	3,288	3,441	3,353	3,226	3,231	3,072	3,146	3,176	3,114	3,118	3,138
Plus means-tested cash transfers (official definition)	2,936	3,133	3,066	3,005	2,928	2,717	2,831	2,874	2,866	2,828	2,810
Plus food and housing benefits	2,572	2,708	2,621	2,631	2,520	2,250	2,347	2,436	2,354	2,293	2,335
Less Federal taxes	2,577	2,717	2,644	2,638	2,533	2,256	2,353	2,446	2,363	2,306	2,354
Number of individuals removed from poverty due to (thousands):											
Social insurance (including Social Security)	7,097	7,380	7,531	7,546	7,612	7,937	8,054	8,374	8,627	8,679	8,833
Means-tested cash, food and housing benefits	716	733	732	595	711	822	799	740	760	825	803
Federal taxes	−5	−9	−23	−7	−13	−6	−6	−10	−9	−13	−19
Percent of individuals removed from poverty due to (thousands):											
Social insurance (including Social Security)	68.3	68.2	69.2	70.1	70.2	72.1	71.9	72.5	73.5	73.6	73.8
Means-tested cash, food and housing benefits and Federal taxes	6.8	6.7	6.5	5.5	6.4	7.4	7.1	6.3	6.4	6.9	6.5
Poverty gap (millions of 1987 dollars):											
Cash income before transfers	34,245	36,755	36,983	36,633	36,430	36,869	37,796	39,144	39,230	39,242	39,596
Plus social insurance (other than Social Security)	32,635	35,184	35,751	35,528	35,119	35,605	36,553	37,904	37,833	38.300	38.436

TABLE 21.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR INDIVIDUALS IN UNITS WITH ALL MEMBERS 65 OR OLDER, 1979–89—Continued

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Plus Social Security	5,854	5,864	5,706	5,852	5,683	5,232	5,508	5,611	5,540	5,273	5,426
Plus means-tested cash transfers (official definition)	3,901	3,916	3,999	4,163	3,728	3,306	3,733	3,965	3,924	3,725	3,806
Plus food and housing benefits	3,369	3,329	3,389	3,634	3,242	2,770	3,151	3,385	3,274	3,037	3,141
Less Federal taxes	3,379	3,342	3,398	3,643	3,254	2,777	3,158	3,395	3,285	3,046	3,153
Percentage reduction in poverty gap due to:											
Social insurance (including Social Security)	82.9	84.0	84.6	84.0	84.4	85.8	85.4	85.7	85.9	86.6	86.3
Means-tested cash, food and housing benefits and Federal taxes	7.2	6.9	6.2	6.0	6.7	6.7	6.2	5.7	5.7	5.7	5.7
Poverty rate for individuals (in percent):											
Cash income before transfers	60.0	60.1	58.9	57.3	56.2	56.3	56.6	55.8	55.6	54.9	54.9
Plus social insurance (other than Social Security)	58.7	59.1	58.2	56.4	55.3	55.5	55.7	54.7	54.7	54.2	54.1
Plus Social Security	19.0	19.1	18.1	17.2	16.8	15.7	15.9	15.3	14.7	14.5	14.4
Plus means-tested cash transfers (official definition)	17.0	17.4	16.6	16.0	15.2	13.9	14.3	13.9	13.6	13.2	12.9
Plus food and housing benefits	14.9	15.0	14.2	14.0	13.1	11.5	11.8	11.8	11.1	10.7	10.7
Less Federal taxes	14.9	15.1	14.3	14.0	13.1	11.5	11.9	11.8	11.2	10.7	10.8

Source: Congressional Budget Office and Committee staff.

EXPLANATIONS FOR INCREASES IN POVERTY BETWEEN 1979 AND 1989

As noted in table 17 of the previous subsection, between 1979 and 1989 the number of poor persons (using a modified definition of poverty which includes market and social insurance income, means-tested transfers and Federal taxes) increased from 21.6 to 28.9 million, representing a net increase in the poverty population of 38 percent, and an increase in the poverty rate from 9.9 percent to 11.8 percent. The aggregate "poverty gap," which is the difference between a poor family's disposable income and the poverty level, summed across all poor families, grew from $28.6 billion to $38.9 billion (in real 1987 dollars), representing an increase of $10.3 billion.

Several factors have potentially contributed to these changes in the level of poverty and the poverty gap, including demographic changes (size and composition of the population), changes in wages and other private sources of income (market income) relative to inflation, and changes in the effectiveness of Federal social programs and tax policy. The goal of this analysis is to determine how significant a contribution each of these factors has made to the increase in the number of poor persons and the poverty gap noted above. Because individuals in different family types have been differentially affected by each of these factors, this analysis seeks to highlight trends for individuals in various family types.

METHODOLOGY

A family is officially classified as poor if cash income (wages, pensions, Social Security benefits, AFDC benefits and all other forms of cash income) is less than the poverty threshold. The poverty threshold in 1989 was $12,675 for a family of four persons. For the purpose of this analysis, this official definition of poverty was modified by adding near-cash benefits (such as the value of food and housing benefits) to income, and subtracting Federal income and payroll taxes from income. If this "disposable income" was less than the poverty threshold, all the individuals in the family were classified as poor. With the exception of changes in Government health programs such as Medicare and Medicaid, this "disposable income" poverty measure is sensitive to all policy changes in the major social insurance and means-tested programs. To highlight the difference between this modified definition of poverty and the official definition of poverty, note that under the official definition of poverty the number of persons classified as poor increased 25.1 percent between 1979 and 1989, from 25.2 million to 31.5 million. The official poverty rate increased from 11.6 to 12.8 percent.

This analysis is based on the data in the previous subsection for 1979 and 1989 which describe the antipoverty effectiveness of various cash and noncash sources of income. To determine what factors have contributed to changes in the poverty of individuals in each family type, this analysis compares the effectiveness of each factor in removing individuals from poverty in 1979 with its effectiveness in 1989. A similar analysis is repeated to evaluate which factors have contributed most to the increase in the poverty gap. Note that these findings are only suggestive of general trends over this specified time period.

As an example, the numbers for individuals in families headed by an unmarried person were calculated based on the following set of data taken from table 19.

	1979 actual	1979: marginal percent left in poverty	1989 expected	1989 actual
Total population	22,978,000		29,255,000	29,255,000
Number poor, market income only	11,480,000	50.0	14,628,000	14,074,000
Number poor, market and social insurance income	10,367,000	90.3	12,709,000	13,820,000
Number poor, market and social insurance income and means-tested transfers (including food and housing)	6,901,000	66.6	9,204,000	10,636,000
Number poor, all cash income and means-tested transfers, after Federal taxes (payroll and income)	6,925,000	100.3	10,668,000	10,648,000

These data show that if one takes into account market income only, 50.0 percent of individuals in this family type would have been classified as poor in 1979. If market income had been as successful in taking people out of poverty in 1989 as in 1979, 14,628,000 (approximately 50.0%×29,255,000) individuals would have been poor counting only market income. However, 14,074,000 individuals were actually poor in 1989, implying a decrease in the poverty population of 554,000 due to market income.

In 1979, of those 11,480,000 left in poverty counting only market income, 90.3 percent (or 10,367,000) were still in poverty after adding in social insurance. To determine the marginal effect of social insurance income on the increased number of poor between 1979 and 1989, one applies this percentage to the number actually poor in 1989 after market income. If social insurance income had been as successful in taking people out of poverty in 1989 as in 1979, 12,709,000 (90.3%×14,074,000) individuals would have been poor counting both market and social insurance income. However, 13,820,000 individuals were actually poor in 1989, implying an increase in the poverty population due to social insurance income of 1.1 million. This methodology was repeated to gauge the impact of both means-tested transfers and Federal taxes on the increased number in poverty.

Because the population grew 12.9 percent over the 1979–89 period, the effect of "average" population growth was computed. Counting all sources of income (market and social insurance income, means-tested transfers, and Federal taxes), 30.1 percent of the population was left in poverty in 1979. Assuming these sources of income had the same effect on the number poor in 1989 as in

1979, but population grew 12.9 percent, we would expect an increase in the poverty population of 892,213 (22,978,000× 12.9%×30.1%).

Finally, the increase in the number poor that could not be attributed to the changed effectiveness of the various income sources or to average population growth was attributed to an "other" category. Among other things, this category would take into account above- or below-average population growth.

This procedure was followed to determine the causes for the increases in poverty and the poverty gap for each family type.

EXPLANATIONS FOR THE INCREASE IN THE POVERTY POPULATION

Table 22 presents data which suggest which factors contributed to the increase in the number of poor persons between 1979 and 1989, broken down by type of family. The last column of the table illustrates the overall contribution of each factor. Based on this methodology, changes in means-tested programs added 2.2 million people to the poverty population, changes in market income removed 1.0 million and changes in social insurance programs added roughly 1.0 million. Population growth and all other changes added about 5.0 million. In percentage terms, the largest contributing factor was the growth in population (38 percent), followed by the reduced effectiveness of means-tested welfare programs (30 percent), changes in demographics (26 percent), and the reduced effectiveness of social insurance programs (13 percent).

Individuals in families with children headed by an unmarried person accounted for 51 percent of the total increase in the number of poor persons, although they comprise but 12 percent of the population. Means-tested welfare programs tend to be targeted toward this group, and they rely more heavily on these programs to escape poverty than other individuals. The reduced effectiveness of means-tested welfare programs along with population growth and other residual changes accounted for 107 percent of the increase in poverty among this group.

Individuals in families with children headed by a married couple accounted for 25 percent of the total increase in the number of poor persons, although they comprise 44 percent of the population. These individuals are often not eligible for means-tested programs and tend to rely more heavily on earnings to escape poverty. Declining market incomes relative to inflation were a major contributing factor to their increase in poverty (67 percent), followed by the reduced effectiveness of means-tested programs (42 percent). Population growth and "other" factors (primarily demographic changes) reduced the number in poverty in this group by 564,000, representing an offsetting contribution of 31 percent to the total increase in poverty.

Individuals in households with all members over 65, who comprise 9 percent of the total population, experienced a very small net decline in the size of their poverty population. Market income, which includes private pensions, reduced the official pretransfer poverty rate over this 8-year period by 12 percentage points.

Individuals in "other" family types include nonelderly individuals and married couples without children, and other family groups without children that are not 100 percent elderly. Individuals in this group accounted for 28 percent of the increase in the poverty population, although they comprise 19 percent of the total population. The reduced effectiveness of social insurance programs accounted for 37 percent of the increase in the number poor. This group was affected by tightened disability insurance eligibility. As individuals in this group tend not to be eligible for most types of means-tested welfare benefits, changes in welfare programs contributed much less to increases in this group's poverty population.

EXPLANATIONS FOR THE INCREASE IN THE POVERTY GAP

The poverty gap is an important complementary approach to evaluating poverty. Over time, changes in income and the effectiveness of Federal programs and policies may do little to reduce the number who are counted as poor, but may have a very real impact in reducing the degree of poverty. This is especially relevant when one considers that eligibility was tightened in some Federal programs, such as UI and Social Security, while benefits were reduced in others, such as AFDC and food stamps. Eligibility tightening in programs tends to make a greater percentage contribution to increases in the poverty gap than to increases in the poverty population.

Table 23 presents data which suggest the factors contributing to the increase in the poverty gap between 1979 and 1989, broken down by type of family. The last column of the table illustrates the overall contribution of each factor. Population growth, changes in market incomes and other residual changes accounted for 58 percent of the increase in the aggregate poverty gap, followed by social insurance programs (24 percent), means-tested program changes (16 percent), and changes in Federal tax policy (1 percent).

TABLE 22.—SOURCES OF THE INCREASE IN THE POVERTY POPULATION BETWEEN 1979 AND 1989, BY TYPE OF FAMILY, USING OFFICIAL POVERTY THRESHOLDS

[Thousands of persons]

	Type of family					Total
	All families with children under 18			All members over age 65	Other	
	Unmarried head	Married couple	Total			
Increased number of after-transfer poor (1979–1989) due to:						
Average population growth	895	867	1,762	333	696	2,791
Market income changes	−542	1,210	668	−1,125	−509	−966
Social insurance program changes	330	541	871	−652	753	972
Welfare program changes	1,956	346	2,302	−120	28	2,210
Federal tax changes	−25	268	243	14	192	430
Other (demographic)	1,109	−1,431	−322	1,326	893	1,898
Total increase	3,723	1,802	5,525	−223	2,033	7,335
Percent of total increase	51	25	75	−3	28	100
Percent of total population	12	44	55	9	19	100
Percentage contribution, by source:						
Average population growth	24	48	32	NA	34	38
Market income changes	−15	67	12	NA	−25	−13
Social insurance program changes	9	30	16	NA	37	13
Welfare program changes	53	19	42	NA	1	30
Federal tax changes	−1	15	4	NA	8	6
Other (demographic)	30	−79	−6	NA	44	26
Total	100	100	100	NA	100	100

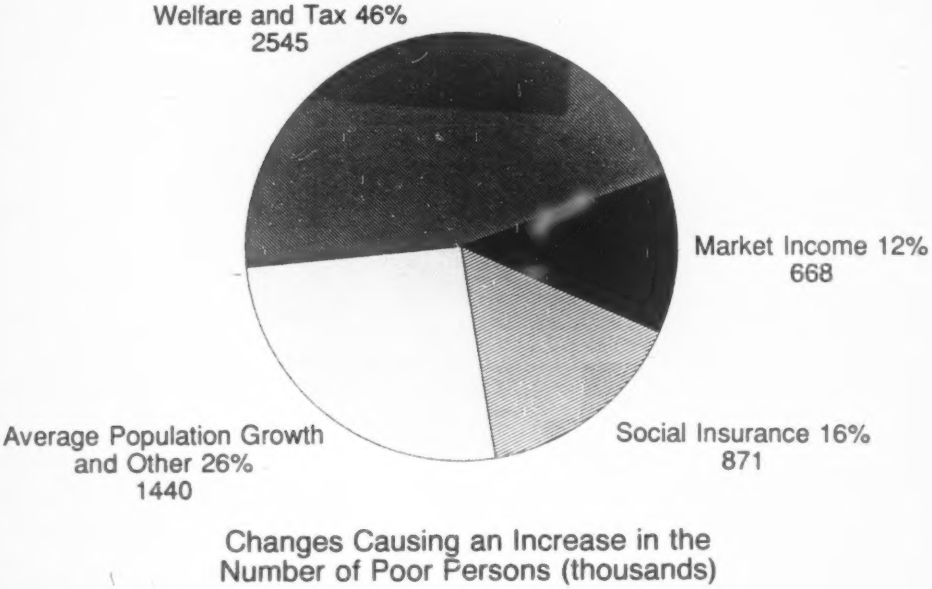
TABLE 23.—SOURCES OF THE INCREASE IN THE POVERTY GAP BETWEEN 1979 AND 1989, BY TYPE OF FAMILY

[Constant 1987 dollars, in millions]

	Type of family					Total
	All families with children under 18			All members over age 65	Other	
	Unmarried head	Married couple	Total			
Increase in poverty gap 1979–1989 due to:						
Market incomes/demographic/other	2,177	688	2,865	1,505	3,652	8,022
Social insurance program changes	1,016	716	1,733	−1,465	3,030	3,297
Welfare program changes	2,421	−267	2,154	20	94	2,268
Federal tax changes	−60	42	−18	3	211	196
Total increase	5,555	1,179	6,734	63	6,986	13,782
Percent of total increase	40	9	49	0	51	100
Percentage contribution, by source:						
Market incomes/demographic/other	39	58	43	NA	52	58
Social insurance program changes	18	61	26	NA	43	24
Welfare program changes	44	−23	32	NA	1	16
Federal tax changes	−1	4	0	NA	3	1
Total increase	100	100	100	NA	100	100

Chart 4, based on numbers in table 22, illustrates the causes for the increase in the number of poor persons among families with children under 18 years old between 1979 and 1989.

CHART 4. SOURCES OF THE INCREASE IN THE NUMBER OF POOR PERSONS IN FAMILIES WITH CHILDREN UNDER 18 YEARS OLD, BETWEEN 1979 AND 1989



Welfare benefits reduce the poverty gap between income and the poverty line in order to bring as many poor households as possible up to and above the level of poverty. Prewelfare poverty shows the percentage of people who are poor before welfare is added to their other sources of income (table 25). In each State, the percentage reduction in the prewelfare poverty gap exceeds the percentage reduction in the rate of prewelfare poverty. Maximum welfare benefits in every State are less than the poverty threshold. Cash welfare programs throughout the United States reduce poverty by 0.7 percent to 11.9 percent if measured in terms of the decline in the level of poverty. However, if measured in terms of the reduction in the poverty gap, percentages range from 10.7 percent in Nevada to 42.0 percent in Wisconsin. These wide discrepancies exist among the States due to newly developed data on State poverty rates and the impact of State income support policies on poverty.[11]

---

[11] Plotnick, Robert D. "How Much Poverty is Reduced by State Income Transfers?" Monthly Labor Review, July 1989.

TABLE 24.—SOURCES FOR THE INCREASE IN THE POVERTY POPULATION FOR ALL FAMILIES AND FAMILIES WITH CHILDREN, FOR SELECTED YEARS RELATIVE TO 1979

[In thousands]

	Total population					Families with children				
	1986	1987	1988	1989	EITC [1]	1986	1987	1988	1989	EITC [1]
Increased number of after-transfer poor from 1979 due to:										
Average population growth	2,054	2,285	2,547	2,791	2,791	1,296	1,442	1,608	1,762	1,762
Market income changes	1,914	1,127	78	−966	−966	2,492	1,837	1,114	668	668
Social insurance program changes	965	947	860	972	972	695	927	572	871	871
Means-tested program changes	3,013	3,168	2,898	2,210	2,210	2,982	3,030	2,921	2,302	2,302
Federal tax changes	1,335	469	−38	430	−863	1,107	232	−27	243	−990
Other (primarily demographic)	362	798	1,262	1,898	1,898	−1,011	−811	−473	−322	−322
Total increase	9,643	8,794	7,608	7,335	6,042	7,561	6,657	5,714	5,525	4,292
Percent of total increase	100	100	100	100	100	78	76	75	75	71
Percent of total population	100	100	100	100	100	60	56	55	55	55
Percentage contribution, by source:										
Average population growth	21	26	33	38	46	17	22	28	32	41
Market income changes	20	13	1	−13	−16	33	28	19	12	16
Social insurance program changes	10	11	11	13	16	9	14	10	16	20
Means-tested program changes	31	36	38	30	37	39	46	51	42	54
Federal tax changes	14	5	0	6	−14	15	3	0	4	−23
Other (primarily demographic)	4	9	17	26	31	−13	−12	−8	−6	−7
Total	100	100	100	100	100	100	100	100	100	100

---

[1] Using 1989 data, this column adjusts for the changes in EITC rates which will be fully implemented in 1994.

Using the same methodology as described earlier, table 24 illustrates sources of the increase in the poverty population for all families and families with children for selected years. As expected, average population growth slowly increased the number who are poor. As the economic expansion continued, the number placed into poverty due to market income changes decreased from 1.9 million individuals in 1986 to decreasing the poverty roles (in contrast to 1979) by almost 1 million individuals in 1989. The number of people added to poverty because of social insurance program changes has remained remarkably the same at 1 million individuals. The number of people added to poverty because of changes in means-tested programs decreased from slightly over 3 million in 1986 and 1987 to around 2.2 million in 1989. There were several policy changes enacted in 1988 that account for this improvement. Finally, the most improvement from a policy perspective has occurred in Federal tax law. Before the increases in the personal exemption and the EITC took effect, 1.3 milion individuals were added to poverty relative to 1979 because of increases in Federal tax burdens to low-income individuals. With the passage of the Tax Reform Act of 1986 and the increases in the EITC in the Omnibus Reconciliation Act of 1990, almost 1 million people have been subtracted from poverty. The total Federal tax policy changes since 1986 are responsible for removing over 2 million individuals from poverty.

TABLE 25.—PERCENT OF POOR REDUCED BY RECEIPT OF WELFARE BENEFITS, AND RESULTING REDUCTION IN POVERTY GAP, MID-1980'S

State	Official poor [1]	Prewelfare poor [2]	Persons taken out of poverty by welfare [3] (percent)	Reduction in prewelfare poverty gap [4]
United States	14.0	14.9	6.0	26.3
New England:				
Maine	11.1	12.1	8.3	30.1
New Hampshire	5.6	6.1	8.2	16.0
Vermont	10.2	11.4	10.5	33.3
Massachusetts	8.8	9.9	11.1	38.1
Rhode Island	11.2	12.1	7.4	38.5
Connecticut	7.2	7.3	1.4	36.2
Mid-Atlantic:				
New York	15.2	16.6	8.4	39.2
New Jersey	9.5	10.3	7.8	31.5
Pennsylvania	12.4	13.5	8.1	32.6
East North Central:				
Ohio	12.4	12.9	3.4	26.7
Indiana	12.2	12.5	2.4	14.3
Illinois	15.0	15.8	5.1	30.1
Michigan	14.4	15.6	7.7	35.9
Wisconsin	11.8	13.4	11.9	42.0
West North Central:				
Minnesota	11.5	12.2	5.7	31.9
Iowa	16.5	17.0	2.9	22.7
Missouri	14.3	14.8	3.4	19.0
North Dakota	14.9	15.3	2.6	11.5
South Dakota	16.2	16.5	1.8	12.0

TABLE 25.—PERCENT OF POOR REDUCED BY RECEIPT OF WELFARE BENEFITS, AND RESULTING REDUCTION IN POVERTY GAP, MID-1980'S—Continued

State	Official poor [1]	Prewelfare poor [2]	Persons taken out of poverty by welfare [3] (percent)	Reduction in prewelfare poverty gap [4]
Nebraska	14.6	14.7	.7	15.1
Kansas	11.2	12.1	7.4	15.0
South Atlantic:				
Delaware	11.3	11.7	3.4	18.1
Maryland	8.5	8.8	3.4	25.1
District of Columbia	19.2	19.9	3.5	23.3
Virginia	10.6	11.3	6.2	22.8
West Virginia	22.8	23.7	3.8	21.1
North Carolina	14.0	14.9	6.0	20.2
South Carolina	17.6	18.3	3.8	20.2
Georgia	15.6	16.3	4.3	22.2
Florida	13.3	13.9	4.3	15.6
East South Central:				
Kentucky	18.5	19.3	4.1	15.2
Tennessee	17.8	19.1	6.8	21.6
Alabama	21.5	22.0	2.3	17.2
Mississippi	25.6	27.3	6.2	19.9
West South Central:				
Arkansas	22.4	23.6	5.1	19.3
Louisiana	20.8	21.6	3.7	16.5
Oklahoma	15.5	16.0	3.1	14.4
Texas	16.2	16.7	3.0	12.0
Mountain:				
Montana	16.3	16.8	3.0	13.8
Idaho	16.4	16.6	1.2	11.5
Wyoming	12.3	12.8	3.9	14.7
Colorado	10.8	11.1	2.7	18.5
New Mexico	20.7	21.4	3.3	16.7
Arizona	13.4	13.6	1.5	12.0
Utah	11.9	12.4	4.0	16.3
Nevada	12.4	12.8	3.1	10.7
Pacific:				
Washington	11.7	12.4	5.7	25.8
Oregon	12.6	13.2	4.5	16.9
California	13.4	15.1	11.3	37.4
Alaska	10.4	11.8	11.9	27.4
Hawaii	9.9	10.6	6.6	28.2

---

[1] This measure is based on the Bureau of the Census definition of money income. Capital gains and income such as fringe benefits or government benefits from food stamps or medicare are excluded.

[2] The percentage of people who are poor before welfare is added to their other sources of income. Persons in this group need welfare to escape poverty.

[3] Defined as (prewelfare poor minus official poor)/prewelfare poor.

[4] Defined as (prewelfare gap minus official gap)/prewelfare gap.

Source: Computations from the March 1985, 1986, and 1987 Current Population Survey computer tapes.

TRENDS IN FAMILY INCOME AND INCOME INEQUALITY

There are several different approaches to measuring trends in family income and income inequality (see table 26). These approaches all track trends in family income by looking at income over time, adjusted for inflation, by income quintiles. Income quintiles are fifths of the income distribution, defined by ordering all relevant family units from that with the lowest income to that with the highest. Quintiles may also be defined separately for different types of families.

Most of the analysis focuses on data for 3 years: 1973 and 1979, which reflect peak years in the business cycle, and 1989, which is the most recent year for which data are available. Using only 3 years simplifies the analysis significantly. (Table 35 presents data for most years between 1973 and 1989.)

To examine changes in family incomes over time, the dollar amounts must be adjusted for inflation to compare actual buying CPI-X1, an index of the cost of a market basket of goods and services representing the average consumption of the urban population. The CPI-X1 is a revised version of the official CPI that provides a consistent treatment of the costs of homeownership over the years examined here.[12]

Results for all families: Income levels

This section examines changes in income levels for all families. In addition to using the CPI-X1, the analysis here differs from tabulations published by the Bureau of the Census in two ways. First, the definition of families includes unrelated individuals (one-person families). Second, four different income measures are examined to provide alternative methods of analyzing changes in economic well-being.

Inflation adjustment only.—Part A of table 26 shows changes in mean family cash incomes, in constant 1989 dollars, between 1973 and 1989. By this measure, which is commonly used to analyze changes over time in the income distribution, the average income for all families increased 8.7 percent over the period, with most of the growth occurring between 1979 and 1989. There were, however, different trends among income quintiles: the mean family cash income of the lowest quintile fell 3.2 percent between 1973 and 1989 and the income of the highest quintile rose 17.1 percent.

---

[12] The official CPI is viewed by many analysts as having overstated the growth in housing costs during the late 1970s when interest rates increased rapidly. Prior to 1983, the housing component of the official CPI reflected both the flow of services and the investment aspects of homeownership; only the former is appropriate in an index measuring consumption costs.

In 1983, the Bureau of Labor Statistics began using a "rental-equivalence" measure of the costs of homeownership in calculating the official CPI. This measure incorporates only the consumption aspects of owning a home, not the investment aspects, and is therefore less affected by changes in housing prices and mortgage rates. In addition, the relative weight given to housing costs is only about half what it had been before the change.

The official CPI is not adjusted for years prior to the change in the treatment of housing costs. Using it to adjust poverty thresholds and incomes in years before 1983 has the effect of "locking in" the overstatement in housing costs, making families appear worse off than they actually are when incomes are compared between years before and after the change.

The CPI-X1 series is an estimate of what the CPI would be had the new treatment of housing costs been in place since 1967.

TABLE 26.—ALTERNATIVE MEASURES OF FAMILY INCOME, BY INCOME QUINTILE AND CHANGE OVER TIME, 1973, 1979, 1989, FOR ALL FAMILIES

[In 1989 dollars]

Quintile	1973	1979	1989	Percent change	
				1973–89	1979–89
I. Pre-Tax Cash Income					
A. Mean family cash income (family weighted):					
Lowest	6,061	5,994	5,866	−3.2	−2.1
Second	15,416	15,306	15,107	−2.0	−1.3
Middle	25,909	25,609	25,823	−0.3	0.8
Fourth	37,946	38,680	40,374	6.4	4.4
Highest	66,364	68,230	77,716	17.1	13.9
Average	30,341	30,764	32,978	8.7	7.2
B. Adjusted family income (person weighted): [1]					
Lowest	5,216	5,218	4,993	−4.3	−4.3
Second	11,232	11,938	12,097	7.7	1.3
Middle	16,368	17,789	18,983	16.0	6.7
Fourth	22,863	25,016	27,643	20.9	10.5
Highest	39,805	42,826	51,230	28.7	19.6
Average	19,096	20,557	22,990	20.4	11.8
C. Mean family income per capita (person weighted): [2]					
Lowest	2,795	2,912	2,822	1.0	−3.1
Second	5,906	6,535	6,872	16.4	5.2
Middle	8,628	9,713	10,723	24.3	10.4
Fourth	12,386	14,046	16,058	29.6	14.3
Highest	23,875	26,405	32,237	35.0	22.1
Average	10,718	11,922	13,743	28.2	15.3
II. Post-Tax Income Plus Food and Housing Benefits					
D. Adjusted family income (person weighted): [1]					
Lowest	NA	5,536	5,420	NA	−2.1
Second	NA	10,962	11,019	NA	0.5
Middle	NA	15,495	16,484	NA	6.4
Fourth	NA	21,014	23,240	NA	10.6
Highest	NA	33,883	40,811	NA	20.4
Average	NA	17,374	19,395	NA	11.6

[1] Adjusted family income is income divided by the poverty threshold. Dollar values are obtained by multiplying AFI by the 1-person poverty threshold.

[2] Per capita income is family income divided by family size.

Note.—Data in this table are not directly comparable with data shown in Table 29 of the 1990 Green Book.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

Adjusting for family size.—Mean family income has several shortcomings as a measure of changes in economic well-being. Most notably, it fails to take into account changes in family size and composition: mean family cash income shows a family of one with $30,000 in income being as well off as a family of four with $30,000 in income. This assumption is obviously inappropriate, however, as a family of four requires more income to attain the same standard of living as a single person.

An alternative approach is to measure income on a per capita basis, by dividing total family income by the number of persons in the family. Using mean family cash income per capita, as shown in part C of table 26, yields quite different results. The growth in cash income per capita among all families between 1973 and 1989 is much larger than the growth in mean family cash income: 28.2 percent, compared with 8.7 percent. Moreover, cash income per capita rose for each quintile between 1973 and 1989, whereas mean family cash income rose only for the top two quintiles. These results reflect a decline in family size between 1973 and 1989.

In contrast to mean family cash income, which completely ignores differences in family size, the per capita family income measure assumes that a family of four requires exactly four times as much as a single person to attain the same standard of living. But four persons living together would generally require less than four times as much income. For example, families with more children might require more bedrooms, but not more kitchens. A measure that reflects such "economies of scale" would therefore provide a better method of taking family size into account.

Analysts disagree over the best method of making incomes comparable for families of different sizes, but one readily available candidate is the equivalence scale implicit in the official Federal poverty thresholds. This scale assumes, for example, that a family of four needs about twice as much income as a single person to attain an equivalent standard of living (see table 29). The equivalence scale implicit in the poverty thresholds may not perfectly reflect the disparate needs of families of different sizes, but it probably yields a better assessment of relative economic well-being than making no adjustment (mean family cash income) or assuming no economies of scale (mean family cash income per capita).

The adjusted family income (AFI) measure shown in part B of table 26 incorporates the equivalence scale underlying the poverty thresholds. Each family's cash income is divided by the poverty threshold corresponding to how many persons are in that family, which yields family cash income as a percent of poverty. To express the result in dollars for comparison with the other measures shown in table 26, this AFI measure is then multiplied by the one-person poverty threshold, which varies by family size. (Elsewhere in this study, AFI is expressed as a percent of poverty, not in dollars.)

The AFI measure yields results that are generally intermediate to the mean family cash income and per capita measures. On average, AFI increased 20.4 percent between 1973 and 1989, with a 4.3 percent decline for the lowest quintile and a 28.7 percent increase for the highest quintile. As with the other measures, most of the growth in AFI occurred between 1979 and 1989. Also like the other measures, however, mean AFI declined for the lowest quintile between 1979 and 1989 and rose for the highest quintile.

Adjusting for taxes and noncash income.—In addition to wage and salary earnings, interest, rental income, and dividends, the three income measures discussed above also include pensions and cash transfer payments from governments (such as Social Security and AFDC). They do not take into account the taxes paid by families, however, nor any noncash transfers they receive. These factors can have important effects on families' economic well-being.

The income measure shown in part D of table 26 shows posttax AFI, plus the estimated cash value of food and housing benefits, for 1979 and 1989. (Data for 1973 are not available.) Food benefits reflect the value of food stamps and school lunches; taxes include Federal income and payroll taxes, but not State income taxes. Being more comprehensive, the posttax AFI measure is a better indicator of economic well-being than the pretax AFI measure, and is used extensively in this study.

The growth in posttax AFI plus food and housing benefits between 1979 and 1989 is quite similar to the growth in pretax AFI, both on average and for each income quintile. The most notable difference between the two measures is in their levels in both years. In 1989, posttax AFI is about 9 percent higher than pretax AFI for the lowest quintile, reflecting the receipt of food and housing benefits by families in that quintile. For the highest quintile, posttax AFI is about 20 percent lower than pretax AFI in 1989.

There are two general explanations for the different trends shown by the income measures in table 26. First, family composition and the distribution of persons among family types has changed over time. As shown in table 27, both the number of families with children and the number of people living in such families grew much more slowly between 1973 and 1989 than did the number of families and persons as a whole. Second, the income concepts shown in table 26 are based on quite different concepts. Mean family cash income, for example, is measured for a family as a unit without taking the size of the family into account. Thus in 1989, the lowest quintile based on mean family cash income contained 20 percent of families, but only 14 percent of persons (see table 63 at the end of this section).

Results for all families: Income shares

Another way of tracking income trends is to look at changes in the percentage share of income received by families in each quintile. These shares are shown in table 28 for each of the four income measures discussed above (and shown in table 26).

All four income measures show similar trends in the share of income received by each quintile. Between 1973 and 1989, the shares of each of the lowest three quintiles fell, and the share of the top quintile rose. The measures show different patterns of shares at any point in time, however. In 1989, for example, the share of the top quintile was 47.1 percent when measured on a mean family cash income basis, compared with 42.1 percent when measured on a posttax AFI basis.

Results for specific family types: Pretax cash incomes

The composition of the typical family has changed over time. Compared with 1973 and 1979, there were fewer persons in each family in 1989, on average, and married couples with children made up a smaller fraction of all families. Additional insights can therefore be gained by looking at changes in incomes for specific family types. This analysis distinguishes seven specific family types and four aggregates. The specific family types are:

—*Married couples with children,* which includes families composed of a married couple living only with their own or related children, at least one of whom is under age 18;

—*Single mothers with children,* which includes families composed of unmarried, divorced, separated, or widowed mothers living only with their own or related children, at least one of whom is under age 18;

—*Other families with children;*

—*Nonelderly childless familes,* which includes families composed of two or more related people living together, in which both the family head and the spouse of the head are under age 65 and there are no children under age 18;

—*Nonelderly unrelated individuals,* which includes people over age 17 and under age 65 who are not living with relatives;

—*Elderly childless families,* which includes families composed of two or more related people living together, in which either the family head or the spouse of the head are over age 65 and there are no children under age 18;

—*Elderly unrelated individuals,* which includes people over age 65 who are not living with relatives.

The four aggregates are:

—*All families with children;*

—*Nonelderly childless units,* which includes nonelderly childless families and nonelderly unrelated individuals;

—*Elderly childless units,* which includes elderly childless families and elderly unrelated individuals;

—*All families,* which includes all families and unrelated individuals (i.e., the noninstitutional U.S. population).

Unless otherwise specified, income quintiles for each of the family groupings listed above are computed for that grouping. This procedure permits comparisons within family types, but not across types. The quintile for a particular family says nothing about its place among all families, but measures its position in relation to families of the same type. For example, individuals in the middle quintile of single mothers with children may be in the lowest quintile of the all-families grouping.

Comparisons over time show how the incomes of families of a given type compare with similar families at another time, not how incomes have changed for a particular family. Families may move among income quintiles (as their incomes rise or fall); they may also change types (for example, by having children, or through marriage or divorce). Within family types, the average number of family members and earners may change over time, as may the characteristics of those persons.

TABLE 27.—CHANGES IN POPULATION, FAMILY COMPOSITION, AND INCOME, 1979 AND 1989

	1973	1979	1989	Percent change	
				1973–89	1979–89
A. Distribution of families and persons by family type					
Number of families (in thousands):					
All families	73,166	84,229	101,663	38.9	20.7
Families with children	31,098	32,166	34,768	11.8	8.1
Married couples with children	24,798	24,166	24,378	−1.7	.9
Single Mothers with children	4,126	5,650	7,123	72.6	26.1
Nonelderly childless units	28,183	35,730	46,467	64.9	30.1
Elderly childless units	13,884	16,331	20,428	47.1	25.1
Number of persons (in thousands):					
All families	207,525	217,718	245,846	18.5	12.9
Families with children	134,248	130,426	135,381	.8	3.8
Married couples with children	108,976	101,318	99,471	−8.7	−1.8
Single Mothers with children	14,240	18,132	21,504	51.0	18.6
Nonelderly childless units	50,148	60,514	77,025	53.6	27.3
Elderly childless units	23,129	26,778	33,440	44.6	24.9
B. Size, age composition, and number of earners for all families					
Average number of family members: [1]					
Total	2.87	2.59	2.40	−15.8	−7.3
Under 18	.94	.75	.64	−31.9	−14.7
18 to 64	1.64	1.55	1.47	−10.1	−5.2
65 and older	.30	.28	.29	−1.9	3.6
Average number of earners: [1]					
Total	1.39	1.34	1.29	−6.9	−3.7
Male earners	.81	.75	.69	−15.3	−8.0
Female earners	.57	.59	.60	5.2	1.7
C. Income trends for all families, by income measure					
Income measure (in 1989 dollars):					
Total family cash income (billions)	2,220	2,591	3,353	51.0	29.4
Mean family cash incomes [1]	30,341	30,764	32,978	8.7	7.2
Mean family cash income per capita [2]	10,718	11,922	13,743	28.2	15.3
Adjusted family cash income [2]	19,096	20,557	22,990	20.4	11.8
Adjusted post-tax income [2]	NA	17,374	19,395	NA	11.6
High adult male earner	NA	12,023	12,168	NA	1.2
High adult female earner	NA	4,104	5,623	NA	36.9
Other earners in family	NA	922	893	NA	−3.1
Other private income	NA	2,017	2,696	NA	33.6
Cash transfer income	NA	1,490	1,606	NA	7.8
Noncash transfer income	NA	145	139	NA	−4.0
Taxes	NA	−3,327	−3,733	NA	12.3

---

[1] Family weighted.

[2] Person weighted.

NA–Not available.

Note.—Adjustment for inflation is done using the CPI–U–X1. Per capita income is family cash income divided by family size. Adjusted family income is pre-tax family cash income divided by the poverty threshold corresponding to the number of persons in the family, and multiplied by the 1-person poverty threshold. Adjusted post-tax income is family cash income plus food and housing benefits minus taxes, divided by the poverty threshold corresponding to the number of persons in the family, and multiplied by the 1-person poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Surveys, 1980 and 1990.

TABLE 28.—SHARES OF FAMILY INCOME, BY INCOME QUINTILE AND CHANGE OVER TIME, 1973, 1979, 1989, FOR ALL FAMILIES

[In percent]

Quintile	1973	1979	1989
I. Pre-Tax Cash Income			
A. Mean family cash income (family weighted):			
Lowest	4.0	3.9	3.6
Second	10.2	10.0	9.2
Middle	17.1	16.6	15.7
Fourth	25.0	25.1	24.5
Highest	43.7	44.4	47.1
B. Adjusted family income (person weighted): [1]			
Lowest	5.5	5.1	4.3
Second	11.8	11.6	10.5
Middle	17.1	17.3	16.5
Fourth	23.9	24.3	24.0
Highest	41.7	41.7	44.6
C. Mean family income per capita (person weighted): [2]			
Lowest	5.2	4.9	4.1
Second	11.0	11.0	10.0
Middle	16.1	16.3	15.6
Fourth	23.1	23.6	23.4
Highest	44.6	44.3	46.9
II. Post-Tax Income Plus Food and Housing Benefits			
D. Adjusted family income (person weighted): [1]			
Lowest	NA	6.4	5.6
Second	NA	12.6	11.4
Middle	NA	17.8	17.0
Fourth	NA	24.2	24.0
Highest	NA	39.0	42.1

---

[1] Adjusted family income is income divided by the ratio of the n-person poverty threshold to the 1-person poverty threshold.

[2] Per capita income is family income divided by family size.

Note.—Data in this table are not directly comparable with data shown in Table 30 of the 1990 Green Book.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

TABLE 29.—POVERTY THRESHOLDS AND EQUIVALENCE VALUES FOR DIFFERENT FAMILY SIZES, 1989

	Official poverty threshold	Adjusted poverty threshold	Equivalence value (one person=1)
Family size (persons):			
1	$6,311	$5,797	1.00
2	8,076	7,419	1.28
3	9,885	9,081	1.57
4	12,675	11,644	2.01
5	14,990	13,770	2.38
6	16,921	15,544	2.68
7	19,162	17,603	3.04
8	21,328	19,592	3.38
9 or more	25,480	23,407	4.04

Note.—Poverty thresholds shown for 1- and 2-person families are a weighted average of the separate official thresholds for elderly and non-elderly individuals and families. Adjusted poverty thresholds use the CPI–X1 (1967 equals 100) to adjust for inflation.

Source: Congressional Budget Office.

CHART 5. CHANGES IN FAMILY INCOME BY QUINTILE, 1973–89

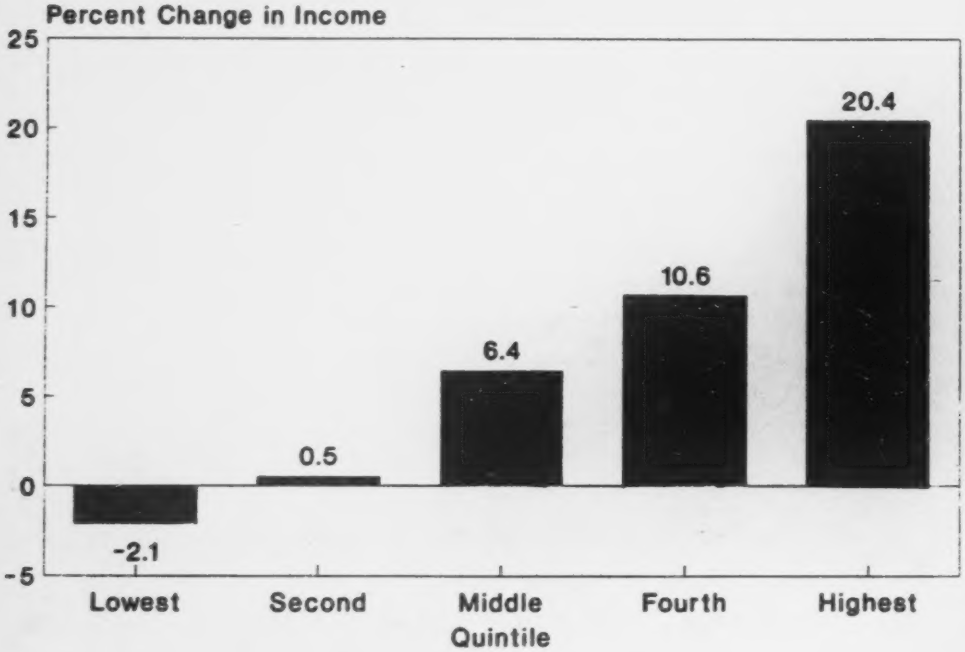
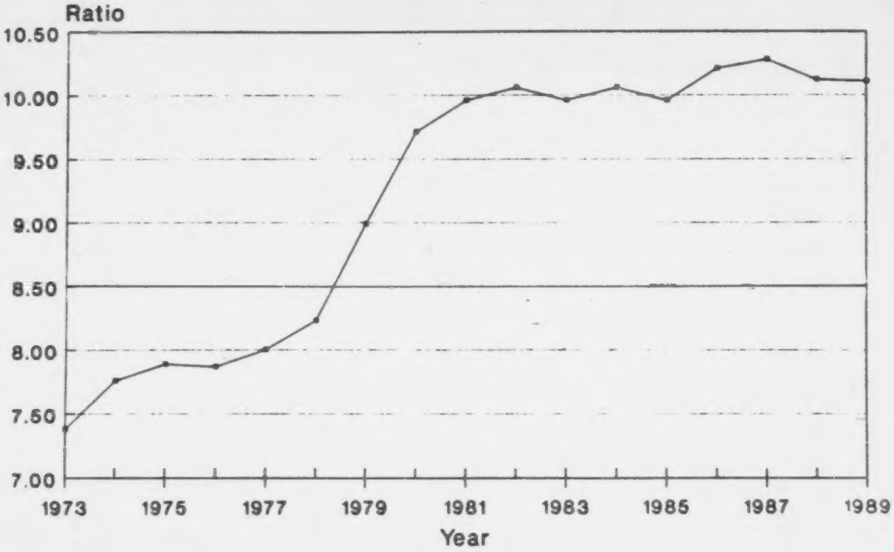


CHART 6. RATIO-AVERAGE INCOME OF RICHEST 20 PERCENT COMPARED TO THE POOREST 20 PERCENT, 1973–89



Note:

Income levels.—Between 1973 and 1989, adjusted family income grew 14.9 percent, on average, for families with children (see Table 30). This compares with an income gain of 20.4 percent for all families. Average AFI fell 16.1 percent during this period for all families with children in the lowest quintile, from 88 percent of poverty to 74 percent of poverty. For the highest quintile in this same group, average AFI rose 25.6 percent, compared with 28.7 percent for all families.

The lowest quintile of married couples with children had a 1.1 percent decline in average AFI between 1973 and 1989; the lowest quintile of single mothers with children fared much worse, with a 23.4 percent decline during the same period. These two family types as a whole, however, showed income gains: 20.6 percent for married couples with children and 16.9 percent for single mothers with children.

Elderly persons without children experienced income gains across the board between 1973 and 1989. For elderly childless units, which includes both single persons and married couples, average AFI rose 24.7 percent for the lowest quintile and 32.0 percent for the highest quintile.

Although elderly childless units generally experienced much greater income gains during the period examined here, their income levels were generally much lower than those of the nonelderly. In 1989, for example, the average income of elderly childless units was about 3.6 times poverty; the average income of nonelderly childless units, by comparison, was about 5.2 times poverty.

TABLE 30.—AVERAGE FAMILY CASH INCOME AS A FRACTION OF POVERTY (ADJUSTED FAMILY INCOME) BY FAMILY TYPE, QUINTILES BASED ON ADJUSTED FAMILY CASH INCOME, WEIGHTED BY PERSONS, 1973, 1979, AND 1989

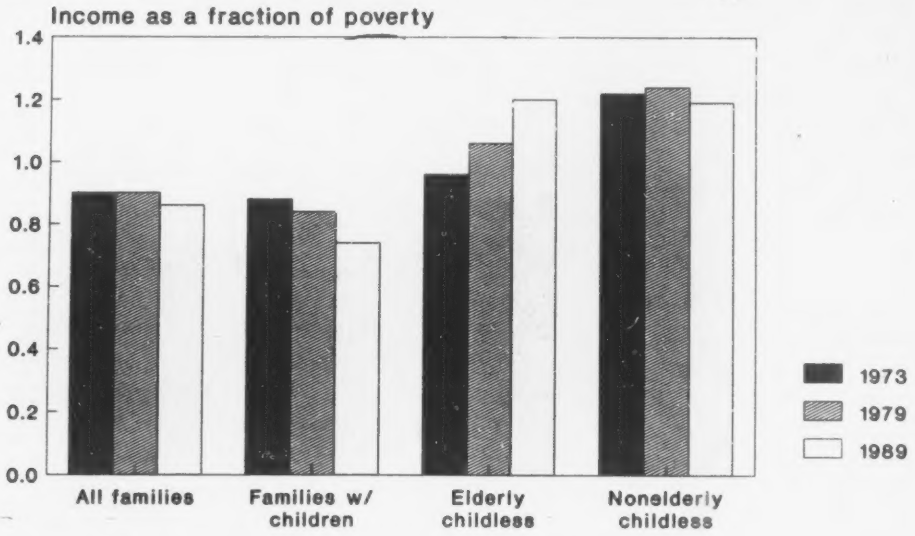
Family type and quintile	1973	1979	1989	Percent change	
				1973–89	1979–89
All families:					
Lowest	0.90	0.90	0.86	−4.3	−4.3
Second	1.94	2.06	2.09	7.7	1.3
Middle	2.82	3.07	3.27	16.0	6.7
Fourth	3.94	4.32	4.77	20.9	10.5
Highest	6.87	7.39	8.84	28.7	19.6
Average	3.29	3.55	3.97	20.4	11.8
All families with children:					
Lowest	.88	.84	.74	−16.1	−11.9
Second	1.88	1.95	1.87	−0.7	−4.2
Middle	2.65	2.84	2.93	10.8	3.3
Fourth	3.54	3.85	4.14	16.9	7.6
Highest	5.73	6.15	7.20	25.6	17.1
Average	2.94	3.13	3.38	14.9	8.0
Married couples with children:					
Lowest	1.16	1.18	1.14	−1.1	−2.9
Second	2.12	2.29	2.34	10.1	2.2
Middle	2.84	3.12	3.34	17.8	7.1
Fourth	3.71	4.11	4.52	21.9	10.2
Highest	5.94	6.41	7.67	29.2	19.8
Average	3.15	3.42	3.80	20.6	11.2
Single mothers with children:					
Lowest	.33	.32	.25	−23.4	−22.9
Second	.71	.75	.64	−9.2	−13.8
Middle	1.03	1.22	1.14	10.7	−6.1
Fourth	1.67	2.01	2.03	21.5	0.6
Highest	3.29	3.65	4.14	26.0	13.5
Average	1.41	1.59	1.64	16.9	3.2
Nonelderly childless units:					
Lowest	1.22	1.24	1.19	−1.8	−3.9
Second	2.81	2.91	2.94	4.5	0.9
Middle	4.09	4.27	4.45	8.9	4.2
Fourth	5.49	5.78	6.29	14.5	8.8
Highest	8.95	9.35	10.94	22.3	17.1
Average	4.51	4.71	5.16	14.4	9.6
Nonelderly childless families:					
Lowest	1.74	1.85	1.80	3.5	−2.8
Second	3.31	3.59	3.68	11.1	2.5
Middle	4.53	4.89	5.20	15.0	6.3

TABLE 30.—AVERAGE FAMILY CASH INCOME AS A FRACTION OF POVERTY (ADJUSTED FAMILY INCOME) BY FAMILY TYPE, QUINTILES BASED ON ADJUSTED FAMILY CASH INCOME, WEIGHTED BY PERSONS, 1973, 1979, AND 1989—Continued

Family type and quintile	1973	1979	1989	Percent change	
				1973–89	1979–89
Fourth	5.88	6.33	7.03	19.5	11.1
Highest	9.33	9.94	11.72	25.7	17.9
Average	4.96	5.32	5.89	18.8	10.7
Nonelderly unrelated individuals:					
Lowest	.51	.61	.61	19.4	−0.4
Second	1.49	1.72	1.83	23.1	6.4
Middle	2.53	2.78	3.00	18.8	8.0
Fourth	3.82	4.03	4.46	16.9	10.6
Highest	7.00	7.11	8.48	21.2	19.3
Average	3.07	3.25	3.68	19.9	13.1
Elderly childless units:					
Lowest	.76	.84	.95	24.7	13.4
Second	1.34	1.50	1.73	28.6	14.8
Middle	1.97	2.26	2.64	34.1	16.9
Fourth	3.02	3.38	4.02	33.2	19.1
Highest	6.54	6.85	8.63	32.0	26.0
Average	2.73	2.97	3.59	31.8	21.2
Elderly childless families:					
Lowest	.96	1.06	1.20	25.3	13.5
Second	1.63	1.86	2.15	31.5	15.2
Middle	2.34	2.67	3.14	34.0	17.4
Fourth	3.50	3.83	4.61	31.8	20.3
Highest	7.12	7.37	9.54	34.0	29.4
Average	3.11	3.36	4.13	32.7	22.9
Elderly unrelated individuals:					
Lowest	.54	.64	.73	35.7	13.6
Second	.93	1.02	1.17	26.1	14.7
Middle	1.23	1.37	1.62	32.2	18.2
Fourth	1.73	2.05	2.46	42.1	20.2
Highest	4.08	4.83	5.58	36.8	15.5
Average	1.70	1.98	2.31	36.0	16.7

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

CHART 7. TRENDS IN INCOME AMONG THE POOREST 20 PERCENT OF THE POPULATION, BETWEEN 1973 AND 1989



Note: Adjusted Family Income, weighted by persons

Income shares.—Tables 31 and 33 present data on income shares by family type. Table 31 is based on average AFI and table 33 is based on mean family cash income. Within most family types, both income measures show declines in shares for the lowest quintile and increases in the shares of the highest quintile between 1973 and 1989.

Trends over time.—Tables 34 and 35 show average AFI and mean cash family income by family type and income quintile for 1973, 1975, and 1977 through 1989. These tables allow comparisons to be made for years other than those shown in tables 26, 30, and 32.

Family composition.—The average number of persons per family has fallen over the past 16 years, from 2.87 in 1973 to 2.40 in 1989 (see table 36). This decline reflects two changes: a decline in the relative number of families with children and a decline in the number of persons per family within most family types. Other things equal, a decrease in family size increases adjusted family income as a given level of cash income must support fewer people.

TABLE 31.—SHARES OF ADJUSTED FAMILY INCOME BY FAMILY TYPE, QUINTILES BASED ON ADJUSTED FAMILY CASH INCOME, WEIGHTED BY PERSONS, 1973, 1979, AND 1989

Family type and quintile	1973	1979	1989
All families:			
Lowest	5.5	5.1	4.3
Second	11.8	11.6	10.5
Middle	17.1	17.3	16.5
Fourth	23.9	24.3	24.0
Highest	41.7	41.7	44.6
All families with children:			
Lowest	6.0	5.4	4.4
Second	12.8	12.5	11.1
Middle	18.0	18.2	17.4
Fourth	24.1	24.6	24.5
Highest	39.0	39.3	42.6
Married couples with children:			
Lowest	7.3	6.9	6.0
Second	13.5	13.4	12.3
Middle	18.0	18.2	17.6
Fourth	23.5	24.0	23.8
Highest	37.7	37.5	40.3
Single mothers with children:			
Lowest	4.6	4.1	3.0
Second	10.1	9.4	7.9
Middle	14.7	15.3	13.9
Fourth	23.7	25.3	24.7
Highest	46.8	45.9	50.5
Nonelderly childless units:			
Lowest	5.4	5.3	4.6
Second	12.5	12.4	11.4
Middle	18.1	18.1	17.2
Fourth	24.4	24.5	24.4
Highest	39.7	39.7	42.4
Nonelderly childless families:			
Lowest	7.0	7.0	6.1
Second	13.4	13.5	12.5
Middle	18.3	18.4	17.7
Fourth	23.7	23.8	23.9
Highest	37.6	37.4	39.8
Nonelderly unrelated individuals:			
Lowest	3.3	3.8	3.3
Second	9.7	10.6	10.0
Middle	16.5	17.1	16.3
Fourth	24.9	24.8	24.3
Highest	45.6	43.8	46.1
Elderly childless units:			
Lowest	5.6	5.7	5.3
Second	9.9	10.1	9.6
Middle	14.4	15.2	14.7
Fourth	22.1	22.8	22.4
Highest	48.0	46.2	48.0

TABLE 31.—SHARES OF ADJUSTED FAMILY INCOME BY FAMILY TYPE, QUINTILES BASED ON ADJUSTED FAMILY CASH INCOME, WEIGHTED BY PERSONS, 1973, 1979, AND 1989—Continued

Family type and quintile	1973	1979	1989
Elderly childless families:			
Lowest	6.1	6.3	5.8
Second	10.5	11.1	10.4
Middle	15.1	15.9	15.2
Fourth	22.5	22.8	22.4
Highest	45.8	43.9	46.2
Elderly unrelated individuals:			
Lowest	6.3	6.5	6.3
Second	10.9	10.3	10.1
Middle	14.4	13.8	14.0
Fourth	20.4	20.7	21.3
Highest	47.9	48.7	48.2

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

TABLE 32.—AVERAGE FAMILY CASH INCOME IN 1989 DOLLARS BY FAMILY TYPE, QUINTILES BASED ON FAMILY CASH INCOME IN DOLLARS, WEIGHTED BY FAMILIES, 1973, 1979, 1989

Family type and income quintile	1973	1979	1989	Percent change 1973–89	Percent change 1979–89
All families:					
Lowest	6,061	5,994	5,866	−3.2	−2.1
Second	15,416	15,306	15,107	−2.0	−1.3
Middle	25,909	25,609	25,823	−0.3	0.8
Fourth	37,946	38,680	40,374	6.4	4.4
Highest	66,364	68,230	77,716	17.1	13.9
Average	30,341	30,764	32,978	8.7	7.2
All families with children:					
Lowest	10,529	9,369	7,714	−26.7	−17.7
Second	23,176	22,365	20,664	−10.8	−7.6
Middle	32,616	33,317	33,067	1.4	−0.8
Fourth	43,426	44,940	47,217	8.7	5.1
Highest	70,420	72,971	81,966	16.4	12.3
Average	36,034	36,592	38,127	5.8	4.2
Married couples with children:					
Lowest	15,450	15,143	14,606	−5.5	−3.6
Second	27,170	28,294	28,660	5.5	1.3
Middle	35,513	37,693	39,683	11.7	5.3
Fourth	45,783	48,616	53,106	16.0	9.2
Highest	72,842	76,547	88,168	21.0	15.2
Average	39,352	41,260	44,846	14.0	8.7
Single mothers with children:					
Lowest	3,505	3,338	2,563	−26.9	−23.2
Second	7,931	8,122	6,737	−15.1	−17.1
Middle	11,922	13,136	11,803	−1.0	−10.1
Fourth	17,867	19,904	19,427	8.7	−2.4
Highest	33,430	35,714	38,394	14.8	7.5
Average	14,930	16,043	15,792	5.8	−1.6
Nonelderly childless units:					
Lowest	5,809	5,863	5,727	−1.4	−2.3
Second	15,886	15,808	15,840	−0.3	0.2
Middle	25,562	25,397	26,154	2.3	3.0
Fourth	37,670	38,217	40,549	7.6	6.1
Highest	67,136	69,142	79,550	18.5	15.1
Average	30,412	30,886	33,565	10.4	8.7
Nonelderly childless families:					
Lowest	13,044	13,881	13,712	5.1	−1.2
Second	25,352	27,773	28,880	13.9	4.0
Middle	35,256	38,599	41,716	18.3	8.1

TABLE 32.—AVERAGE FAMILY CASH INCOME IN 1989 DOLLARS BY FAMILY TYPE, QUINTILES BASED ON FAMILY CASH INCOME IN DOLLARS, WEIGHTED BY FAMILIES, 1973, 1979, 1989—Continued

Family type and income quintile	1973	1979	1989	Percent change	
				1973–89	1979–89
Fourth	47,199	51,058	57,713	22.3	13.0
Highest	76,867	83,026	98,413	28.0	18.5
Average	39,543	42,867	48,093	21.6	12.2
Nonelderly unrelated individuals					
Lowest	2,948	3,504	3,522	19.5	0.5
Second	8,620	9,957	10,621	23.2	6.7
Middle	14,628	16,065	17,389	18.9	8.2
Fourth	22,105	23,330	25,849	16.9	10.8
Highest	40,555	41,215	49,182	21.3	19.3
Average	17,770	18,814	21,315	20.0	13.3
Elderly childless units:					
Lowest	4,148	4,632	5,221	25.9	12.7
Second	7,556	8,367	9,665	27.9	15.5
Middle	11,628	13,325	15,446	32.8	15.9
Fourth	18,576	21,202	25,021	34.7	18.0
Highest	45,276	47,577	59,036	30.4	24.1
Average	17,436	19,021	22,880	31.2	20.3
Elderly childless families:					
Lowest	7,083	7,864	8,940	26.2	13.7
Second	12,074	13,841	15,967	32.2	15.4
Middle	17,200	19,750	23,381	35.9	18.4
Fourth	26,124	28,889	34,869	33.5	20.7
Highest	56,136	57,963	75,091	33.8	29.5
Average	23,723	25,661	31,657	33.4	23.4
Elderly unrelated individuals:					
Lowest	3,108	3,717	4,221	35.8	13.6
Second	5,393	5,932	6,806	26.2	14.7
Middle	7,114	7,963	9,414	32.3	18.2
Fourth	10,046	11,881	14,286	42.2	20.2
Highest	23,626	27,984	32,331	36.8	15.5
Average	9,857	11,495	13,414	36.1	16.7

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

TABLE 33.—SHARES OF FAMILY INCOME BY INCOME QUINTILE AND FAMILY TYPE, QUINTILES BASED ON FAMILY CASH INCOME IN DOLLARS, WEIGHTED BY FAMILIES, 1973, 1979, 1989

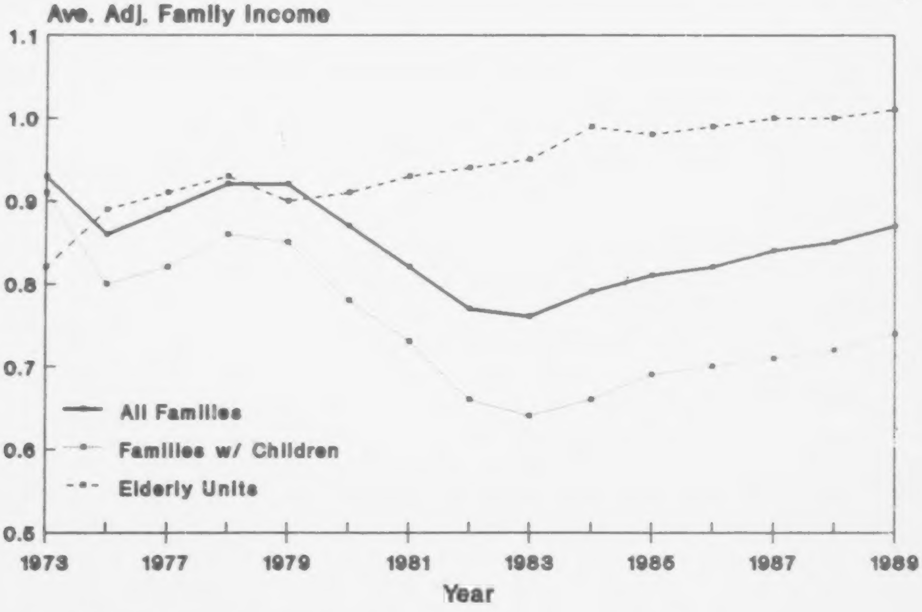
Family type and quintile	1973	1979	1989
All families:			
Lowest	4.0	3.9	3.6
Second	10.2	10.0	9.2
Middle	17.1	16.6	15.7
Fourth	25.0	25.1	24.5
Highest	43.7	44.4	47.1
All families with children:			
Lowest	5.8	5.1	4.0
Second	12.9	12.2	10.8
Middle	18.1	18.2	17.3
Fourth	24.1	24.6	24.8
Highest	39.1	39.9	43.0
Married couples with children:			
Lowest	7.9	7.3	6.5
Second	13.8	13.7	12.8
Middle	18.0	18.3	17.7
Fourth	23.3	23.6	23.7
Highest	37.0	37.1	39.3
Single mothers with children:			
Lowest	4.7	4.2	3.2
Second	10.6	10.1	8.5
Middle	16.0	16.4	14.9
Fourth	23.9	24.8	24.6
Highest	44.8	44.5	48.6
Nonelderly childless units:			
Lowest	3.8	3.8	3.4
Second	10.4	10.2	9.4
Middle	16.8	16.4	15.6
Fourth	24.8	24.7	24.2
Highest	44.2	44.8	47.4
Nonelderly childless families:			
Lowest	6.6	6.5	5.7
Second	12.8	13.0	12.0
Middle	17.8	18.0	17.3
Fourth	23.9	23.8	24.0
Highest	38.9	38.7	40.9
Nonelderly unrelated individuals:			
Lowest	3.3	3.7	3.3
Second	9.7	10.6	10.0
Middle	16.5	17.1	16.3
Fourth	24.9	24.8	24.3
Highest	45.6	43.8	46.1
Elderly childless units:			
Lowest	4.8	4.9	4.6
Second	8.7	8.8	8.4
Middle	13.3	14.0	13.5
Fourth	21.3	22.3	21.9

TABLE 33.—SHARES OF FAMILY INCOME BY INCOME QUINTILE AND FAMILY TYPE, QUINTILES BASED ON FAMILY CASH INCOME IN DOLLARS, WEIGHTED BY FAMILIES, 1973, 1979, 1989—Continued

Family type and quintile	1973	1979	1989
Highest	51.9	50.0	51.6
Elderly childless families:			
Lowest	6.0	6.1	5.6
Second	10.2	10.8	10.1
Middle	14.5	15.4	14.8
Fourth	22.0	22.5	22.0
Highest	47.3	45.2	47.4
Elderly unrelated individuals:			
Lowest	6.3	6.5	6.3
Second	10.9	10.3	10.1
Middle	14.4	13.9	14.0
Fourth	20.4	20.7	21.3
Highest	47.9	48.7	48.2

Source: Congressional Budget Office Tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

CHART 8. AVERAGE ADJUSTED FAMILY CASH INCOME FOR THE LOWEST QUINTILE, 1973–1988



Source: Congressional Budget Office

TABLE 34.—AVERAGE ADJUSTED FAMILY CASH INCOME BY QUINTILE AND FAMILY TYPE, QUINTILES BASED ON PRETAX FAMILY CASH INCOME DIVIDED BY POVERTY THRESHOLDS, WEIGHTED BY PERSON, 1973–89

	1973	1975	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1987R	1988	1989
All families:																
Lowest	0.93	0.86	0.89	0.92	0.92	0.87	0.82	0.77	0.76	0.79	0.81	0.82	0.82	0.84	0.85	0.87
Second	1.97	1.88	1.96	2.05	2.09	2.00	1.93	1.89	1.87	1.93	1.97	2.04	2.06	2.09	2.08	2.10
Middle	2.85	2.76	2.91	3.02	3.09	2.99	2.94	2.90	2.92	3.00	3.05	3.16	3.22	3.26	3.25	3.28
Fourth	3.94	3.84	4.07	4.22	4.31	4.22	4.18	4.17	4.23	4.34	4.41	4.59	4.66	4.73	4.72	4.75
Highest	6.86	6.67	7.02	7.24	7.36	7.16	7.37	7.48	7.57	7.95	8.07	8.37	8.43	8.73	8.60	8.80
Total	3.31	3.20	3.37	3.49	3.55	3.45	3.45	3.44	3.47	3.60	3.66	3.79	3.84	3.93	3.90	3.96
All families with children:																
Lowest	0.91	0.80	0.82	0.86	0.85	0.78	0.73	0.66	0.64	0.66	0.69	0.70	0.70	0.71	0.72	0.74
Second	1.91	1.77	1.86	1.95	1.96	1.85	1.76	1.68	1.64	1.72	1.75	1.81	1.84	1.86	1.86	1.86
Middle	2.67	2.56	2.70	2.80	2.85	2.72	2.65	2.58	2.58	2.66	2.72	2.81	2.88	2.91	2.89	2.92
Fourth	3.55	3.41	3.64	3.77	3.84	3.71	3.64	3.60	3.62	3.76	3.84	3.98	4.07	4.10	4.11	4.12
Highest	5.72	5.60	5.89	6.03	6.11	5.87	5.95	6.06	6.19	6.52	6.65	6.93	7.06	7.19	7.06	7.14
Total	2.95	2.83	2.98	3.08	3.12	2.99	2.94	2.92	2.94	3.07	3.13	3.25	3.31	3.35	3.33	3.36
Married couples with children:																
Lowest	1.19	1.04	1.11	1.18	1.20	1.09	1.03	0.95	0.94	0.98	1.03	1.09	1.10	1.11	1.14	1.15
Second	2.15	2.03	2.16	2.25	2.30	2.20	2.11	2.03	2.01	2.11	2.15	2.25	2.30	2.32	2.31	2.34
Middle	2.86	2.76	2.94	3.05	3.13	3.01	2.95	2.89	2.90	3.00	3.07	3.19	3.27	3.29	3.31	3.34
Fourth	3.72	3.59	3.85	3.99	4.11	3.98	3.92	3.89	3.94	4.09	4.18	4.35	4.43	4.46	4.49	4.51
Highest	5.93	5.84	6.13	6.29	6.38	6.13	6.26	6.38	6.54	6.92	7.08	7.40	7.53	7.60	7.50	7.63
Total	3.17	3.05	3.24	3.35	3.42	3.28	3.25	3.23	3.27	3.42	3.51	3.65	3.72	3.76	3.75	3.80

TABLE 34.—AVERAGE ADJUSTED FAMILY CASH INCOME BY QUINTILE AND FAMILY TYPE, QUINTILES BASED ON PRETAX FAMILY CASH INCOME DIVIDED BY POVERTY THRESHOLDS, WEIGHTED BY PERSON, 1973–89—Continued

	1973	1975	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1987R	1988	1989
Single mothers with children:																
Lowest	0.33	0.32	0.36	0.34	0.33	0.33	0.30	0.27	0.26	0.27	0.27	0.26	0.26	0.26	0.25	0.25
Second	0.72	0.72	0.76	0.73	0.75	0.72	0.68	0.61	0.60	0.62	0.63	0.61	0.60	0.61	0.60	0.64
Middle	1.05	1.05	1.11	1.15	1.22	1.18	1.14	1.01	1.02	1.07	1.08	1.04	1.06	1.08	1.08	1.13
Fourth	1.67	1.68	1.80	1.90	2.01	1.93	1.87	1.78	1.78	1.85	1.92	1.88	1.93	1.94	1.93	1.98
Highest	3.32	3.18	3.49	3.59	3.67	3.69	3.49	3.42	3.41	3.56	3.76	3.77	3.99	4.06	3.90	4.03
Total	1.42	1.39	1.50	1.54	1.60	1.57	1.50	1.42	1.42	1.48	1.53	1.51	1.56	1.59	1.55	1.61
Nonelderly childless units:																
Lowest	1.21	1.13	1.16	1.20	1.23	1.19	1.08	1.06	1.03	1.05	1.07	1.11	1.10	1.13	1.14	1.17
Second	2.79	2.66	2.74	2.85	2.88	2.80	2.68	2.64	2.66	2.66	2.69	2.81	2.80	2.85	2.87	2.89
Middle	4.04	3.88	4.03	4.17	4.22	4.11	4.02	3.96	3.99	4.04	4.09	4.29	4.32	4.36	4.38	4.38
Fourth	5.42	5.22	5.41	5.59	5.70	5.57	5.52	5.47	5.54	5.67	5.76	5.98	6.05	6.13	6.15	6.20
Highest	8.83	8.41	8.78	9.06	9.23	8.87	9.18	9.24	9.25	9.75	9.90	10.20	10.23	10.64	10.57	10.77
Total	4.46	4.26	4.42	4.57	4.65	4.51	4.49	4.47	4.50	4.63	4.70	4.87	4.90	5.02	5.02	5.08
Nonelderly childless familes:																
Lowest	1.73	1.63	1.70	1.81	1.84	1.79	1.59	1.52	1.54	1.55	1.56	1.66	1.68	1.74	1.75	1.77
Second	3.28	3.18	3.35	3.51	3.56	3.47	3.29	3.18	3.26	3.26	3.29	3.49	3.51	3.57	3.61	3.62
Middle	4.48	4.32	4.55	4.74	4.85	4.70	4.57	4.47	4.54	4.64	4.69	4.92	5.00	5.07	5.10	5.14
Fourth	5.82	5.63	5.88	6.09	6.26	6.12	6.03	5.96	6.04	6.23	6.38	6.60	6.68	6.82	6.85	6.94
Highest	9.22	8.81	9.23	9.55	9.84	9.40	9.73	9.77	9.74	10.37	10.59	10.92	10.92	11.36	11.24	11.55
Total	4.91	4.71	4.94	5.14	5.27	5.10	5.04	4.98	5.02	5.21	5.30	5.52	5.55	5.71	5.71	5.80

Nonelderly unrelated individuals:																
Lowest	0.50	0.49	0.54	0.57	0.60	0.58	0.51	0.52	0.47	0.51	0.53	0.50	0.53	0.56	0.57	0.59
Second	1.47	1.42	1.53	1.59	1.69	1.65	1.58	1.60	1.56	1.60	1.66	1.66	1.66	1.68	1.73	1.79
Middle	2.49	2.41	2.54	2.66	2.73	2.68	2.66	2.67	2.67	2.69	2.79	2.84	2.84	2.87	2.92	2.93
Fourth	3.74	3.62	3.76	3.88	3.93	3.91	3.94	3.98	3.99	4.05	4.20	4.31	4.31	4.32	4.37	4.36
Highest	6.78	6.44	6.79	7.05	6.88	6.85	7.18	7.28	7.49	7.62	7.67	7.78	7.96	8.21	8.38	8.30
Total	3.00	2.88	3.03	3.15	3.17	3.13	3.17	3.21	3.24	3.30	3.38	3.43	3.47	3.53	3.59	3.60
Elderly childless units:																
Lowest	0.82	0.89	0.91	0.93	0.90	0.91	0.93	0.94	0.95	0.99	0.98	0.99	1.00	1.00	1.00	1.01
Second	1.44	1.49	1.53	1.58	1.61	1.61	1.66	1.70	1.74	1.76	1.77	1.82	1.83	1.89	1.83	1.84
Middle	2.11	2.19	2.22	2.31	2.42	2.44	2.52	2.58	2.62	2.67	2.69	2.77	2.76	2.88	2.77	2.80
Fourth	3.22	3.30	3.36	3.44	3.60	3.67	3.79	3.94	3.93	3.98	4.00	4.10	4.10	4.30	4.15	4.25
Highest	6.95	6.67	6.95	7.14	7.28	7.50	7.89	8.13	7.88	8.24	8.18	8.46	8.24	8.95	8.50	9.10
Total	2.91	2.91	2.99	3.08	3.16	3.23	3.36	3.46	3.43	3.52	3.53	3.62	3.58	3.80	3.65	3.80
Elderly childless families:																
Lowest	1.03	1.11	1.13	1.15	1.13	1.14	1.17	1.18	1.19	1.24	1.25	1.31	1.30	1.31	1.28	1.27
Second	1.76	1.85	1.88	1.94	2.00	2.02	2.07	2.10	2.11	2.18	2.21	2.30	2.29	2.35	2.28	2.28
Middle	2.51	2.59	2.64	2.73	2.85	2.91	2.96	3.03	3.03	3.12	3.17	3.26	3.26	3.38	3.26	3.32
Fourth	3.71	3.79	3.88	3.92	4.08	4.18	4.30	4.40	4.40	4.48	4.50	4.64	4.63	4.82	4.72	4.36
Highest	7.58	7.30	7.62	7.82	7.83	8.16	8.49	8.75	8.40	8.96	8.93	9.24	8.93	9.65	9.25	10.05
Total	3.32	3.33	3.43	3.51	3.58	3.68	3.80	3.90	3.82	4.00	4.01	4.15	4.08	4.30	4.16	4.36
Elderly unrelated individuals:																
Lowest	0.57	0.66	0.72	0.73	0.68	0.72	0.72	0.71	0.74	0.77	0.75	0.73	0.75	0.75	0.76	0.77
Second	0.99	1.03	1.07	1.10	1.09	1.10	1.11	1.16	1.17	1.19	1.18	1.17	1.20	1.20	1.19	1.25
Middle	1.31	1.34	1.38	1.45	1.46	1.45	1.50	1.58	1.65	1.61	1.61	1.61	1.65	1.72	1.65	1.72
Fourth	1.85	1.93	1.98	2.11	2.19	2.16	2.31	2.48	2.60	2.51	2.48	2.52	2.51	2.70	2.56	2.61
Highest	4.35	4.23	4.45	4.71	5.15	5.05	5.64	6.02	6.06	5.75	5.55	5.70	5.73	6.51	5.75	5.92
Total	1.81	1.84	1.92	2.02	2.12	2.10	2.26	2.39	2.45	2.37	2.31	2.35	2.37	2.58	2.38	2.45

Note: Adjusted family income equals total pre-tax family cash income divided by the appropriate poverty threshold. Data in this table are not directly comparable with other tables in this section because separate poverty thresholds by age, gender, and rural residence status are used here. In 1989, the Bureau of the Census revised its methods used to process data from the Current Population Survey. The revisions caused incomes of some families to increase from what they would have been under the old system, as discussed in "Money Income and Poverty Status in the United States: 1988, "Current Population Reports, Series P-60, Number 166, October 1989. To indicate the effects of this change, the table shows two sets of income values for 1987: values obtained using the old processing system are shown in the column labeled 1987 and those from the new system in the column labeled 1987R.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974–90.

TABLE 35.—AVERAGE FAMILY INCOME BY INCOME QUINTILE AND FAMILY TYPE, QUINTILES BASED ON PRE-TAX FAMILY CASH INCOME, WEIGHTED BY FAMILIES, 1973–1989

[In 1989 dollars]

	1973	1975	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1987R	1988	1989
All families:																
Lowest	6,061	5,752	5,780	5,919	5,994	5,754	5,522	5,401	5,305	5,467	5,517	5,526	5,575	5,696	5,685	5,866
Second	15,416	14,512	14,588	14,974	15,306	14,687	14,430	14,258	14,179	14,289	14,520	14,840	14,828	15,168	15,001	15,107
Middle	25,909	24,396	24,800	25,351	25,609	24,771	24,362	24,161	24,029	24,375	24,739	25,512	25,602	26,012	25,668	25,823
Fourth	37,946	36,227	37,341	38,267	38,680	37,399	37,095	36,719	36,960	37,749	38,197	39,459	39,857	40,403	40,063	40,374
Highest	66,364	63,527	66,142	67,460	68,230	65,893	67,186	68,108	68,237	71,283	71,978	74,722	75,071	77,544	76,265	77,716
Average	30,341	28,882	29,731	30,394	30,764	29,701	29,719	29,729	29,743	30,632	30,991	32,011	32,187	32,965	32,537	32,978
All families with children:																
Lowest	10,529	9,223	9,092	9,288	9,369	8,344	7,912	7,111	6,989	7,139	7,344	7,320	7,349	7,475	7,468	7,714
Second	23,176	21,391	21,765	22,335	22,365	20,779	19,887	19,134	18,656	19,333	19,698	20,102	20,381	20,581	20,413	20,664
Middle	32,616	31,024	32,163	32,990	33,317	31,568	30,821	29,945	29,655	30,780	31,340	32,187	33,026	33,204	32,776	33,067
Fourth	43,426	41,549	43,412	44,511	44,940	43,192	42,677	42,067	42,084	43,633	44,424	45,907	46,841	47,202	46,969	47,217
Highest	70,420	68,187	70,959	72,186	72,971	69,576	69,896	70,924	71,863	74,984	76,428	79,667	81,063	82,329	80,652	81,966
Average	36,034	34,274	35,477	36,263	36,592	34,691	34,238	33,836	33,850	35,174	35,847	37,037	37,732	38,159	37,659	38,127
Married couples with children:																
Lowest	15,450	13,753	14,282	14,898	15,148	13,779	13,037	12,129	12,127	12,577	12,939	13,665	13,967	14,130	14,356	14,606
Second	27,170	25,654	26,990	27,804	28,294	26,896	26,001	25,046	24,905	26,050	26,416	27,520	28,208	28,373	28,332	28,660
Middle	35,513	34,235	36,025	37,046	37,693	36,224	35,659	34,841	34,812	36,224	37,074	38,311	39,295	39,473	39,501	39,683
Fourth	45,783	44,265	46,449	47,877	48,616	47,171	46,557	46,258	46,690	48,294	49,431	51,406	52,162	52,605	52,746	53,106
Highest	72,842	71,130	74,055	75,469	76,547	73.070	73,834	75,065	76,348	79,909	81,668	85,310	86,701	87,503	86,156	88,168
Average	39,352	37,807	39,560	40,619	41,260	39,428	39,018	38,668	38,977	40,611	41,505	43,242	44,067	44,422	44,221	44,846

Single mothers with children:																
Lowest	3,505	3,402	3,612	3,441	3,338	3,301	2,985	2,790	2,601	2,636	2,777	2,646	2,611	2,659	2,537	2,563
Second	7,931	7,709	8,080	7,717	8,122	7,446	7,165	6,514	6,429	6,528	6,556	6,341	6,365	6,450	6,347	6,737
Middle	11,922	11,643	12,300	12,380	13,136	12,162	11,972	10,995	10,915	11,154	11,303	10,976	11,117	11,255	11,346	11,803
Fourth	17,867	17,737	18,370	19,000	19,904	18,922	18,347	17,829	17,645	18,376	19,041	18,344	19,043	19,181	18,918	19,427
Highest	33,430	31,560	33,996	34,939	35,714	34,735	34,391	33,445	33,046	34,635	36,370	36,204	38,498	38,931	37,108	38,394
Average	14,930	14,410	15,272	15,495	16,043	15,314	14,972	14,314	14,127	14,665	15,210	14,903	15,527	15,702	15,257	15,792
Nonelderly childless units:																
Lowest	5,809	5,384	5,529	5,682	5,863	5,658	5,176	5,195	4,887	5,118	5,223	5,273	5,307	5,433	5,499	5,727
Second	15,886	14,792	15,074	15,499	15,808	15,269	14,866	14,819	14,717	14,779	15,036	15,518	15,388	15,612	15,686	15,840
Middle	25,562	24,224	24,647	25,314	25,397	24,853	24,466	24,308	24,410	24,494	24,962	25,994	25,890	26,030	26,049	26,154
Fourth	37,670	36,055	36,910	37,972	38,217	37,202	36,987	36,728	37,422	37,896	38,189	39,713	39,904	40,263	40,226	40,549
Highest	67,136	64,043	66,715	68,325	69,142	66,939	68,912	69,834	69,957	73,062	73,531	76,065	76,128	79,028	78,489	79,550
Average	30,412	28,900	29,776	30,559	30,886	29,983	30,082	30,177	30,282	31,069	31,388	32,513	32,524	33,274	33,192	33,565
Nonelderly childless families:																
Lowest	13,044	12,038	12,796	13,601	13,881	13,462	12,166	11,668	11,801	11,988	12,105	12,834	12,972	13,382	13,473	13,712
Second	25,352	24,454	25,960	27,240	27,773	27,062	25,902	25,134	25,757	25,824	26,333	27,626	27,855	28,167	28,452	28,880
Middle	35,256	34,371	36,248	37,772	38,599	37,590	36,764	36,057	37,104	37,665	38,292	39,965	40,320	40,906	40,991	41,716
Fourth	47,199	45,761	48,250	49,868	51,058	50,477	49,962	49,770	50,632	52,076	53,046	54,697	55,426	56,477	56,720	57,713
Highest	76,867	74,102	78,267	80,686	83,026	79,646	82,886	83,914	83,876	89,137	90,325	93,681	93,506	97,324	96,322	98,413
Average	39,543	38,144	40,304	41,824	42,867	41,648	41,537	41,309	41,834	43,338	44,020	45,761	46,015	47,254	47,199	48,093
Nonelderly unrelated individuals:																
Lowest	2,948	2,877	3,188	3,329	3,504	3,375	3,022	3,055	2,776	3,033	3,150	3,009	3,182	3,289	3,350	3,522
Second	8,620	8,358	9,012	9,374	9,957	9,696	9,342	9,452	9,273	9,470	9,867	9,866	9,825	9,930	10,247	10,621
Middle	14,628	14,205	14,947	15,630	16,065	15,770	15,722	15,810	15,806	15,955	16,536	16,843	16,832	17,027	17,316	17,389
Fourth	22,105	21,338	22,265	22,948	23,330	23,189	23,332	23,500	23,612	23,944	24,840	25,507	25,514	25,616	25,897	25,849
Highest	40,555	38,535	40,673	42,270	41,215	41,022	42,452	43,105	44,337	45,101	45,432	46,086	47,116	48,661	49,645	49,182
Average	17,770	17,062	18,017	18,710	18,814	18,611	18,773	18,985	19,161	19,500	19,966	20,262	20,494	20,908	21,296	21,315

TABLE 35.—AVERAGE FAMILY INCOME BY INCOME QUINTILE AND FAMILY TYPE, QUINTILES BASED ON PRE-TAX FAMILY CASH INCOME, WEIGHTED BY FAMILIES, 1973–1989—Continued

[In 1989 dollars]

	1973	1975	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1987R	1988	1989
Elderly childless units:																
Lowest	4,148	4,501	4,701	4,797	4,632	4,766	4,832	4,881	4,969	5,165	5,019	5,008	5,120	5,149	5,142	5,221
Second	7,556	7,815	7,925	8,210	8,367	8,370	8,665	8,968	9,253	9,230	9,246	9,375	9,503	9,829	9,550	9,665
Middle	11,628	12,100	12,208	12,771	13,325	13,414	14,086	14,625	14,986	14,962	14,987	15,404	15,484	16,253	15,506	15,446
Fourth	18,576	19,196	19,349	20,105	21,202	21,672	22,659	23,826	23,900	23,762	24,023	24,526	24,595	25,946	24,733	25,021
Highest	45,276	43,270	44,983	46,042	47,577	48,682	51,674	53,513	52,130	54,104	53,476	55,549	54,097	58,696	55,809	59,036
Average	17,436	17,375	17,833	18,385	19,021	19,380	20,384	21,164	21,048	21,445	21,350	21,973	21,760	23,176	22,150	22,880
Elderly childless families:																
Lowest	7,083	7,663	7,740	7,896	7,864	7,966	8,154	8,289	8,409	8,827	8,755	9,156	9,125	9,247	9,109	8,940
Second	12,074	12,702	12,891	13,374	13,841	14,101	14,466	14,815	14,922	15,360	15,531	16,151	16,212	16,667	16,043	15,967
Middle	17,200	18,055	18,266	18,920	19,750	20,355	20,843	21,747	21,776	22,117	22,334	23,111	23,121	23,939	23,173	23,381
Fourth	26,124	26,618	27,343	27,631	28,889	29,674	30,732	31,877	31,924	32,640	32,630	33,938	33,420	34,791	34,043	34,869
Highest	56,136	53,790	56,355	57,767	57,963	60,094	63,042	65,419	62,797	66,884	66,765	69,112	66,519	71,915	69,219	75,091
Average	23,723	23,765	24,519	25,118	25,661	26,438	27,447	28,429	27,966	29,166	29,202	30,294	29,679	31,317	30,322	31,657
Elderly unrelated individuals:																
Lowest	3,108	3,566	3,899	3,951	3,717	3,932	3,951	3,888	4,040	4,238	4,096	4,019	4,098	4,087	4,147	4,221
Second	5,393	5,611	5,837	5,998	5,932	5,974	6,058	6,346	6,387	6,483	6,405	6,382	6,518	6,578	6,514	6,806
Middle	7,114	7,314	7,526	7,855	7,963	7,907	8,198	8,619	9,001	8,777	8,785	8,806	9,003	9,405	9,036	9,414
Fourth	10,046	10,522	10,785	11,489	11,881	11,769	12,619	13,488	14,234	13,651	13,483	13,709	13,730	14,772	13,973	14,286
Highest	23,626	23,004	24,166	25,616	27,984	27,357	30,736	32,796	33,059	31,358	30,264	31,129	31,312	35,539	31,426	32,331
Average	9,857	10,004	10,442	10,982	11,495	11,388	12,312	13,027	13,344	12,901	12,606	12,808	12,932	14,079	13,024	13,414

Note: In 1989, the Bureau of the Census revised its methods used to process data from the Current Population Survey. The revisions caused incomes of some families to increase from what they would have been under the old system, as discussed in "Money Income and Poverty Status in the United States: 1988," Current Population Reports, Series P-60, Number 166, October 1989. To indicate the effects of this change, the table shows two sets of income values for 1987: values obtained using the old processing system are shown in the column labeled 1987; those from the new system are in the column labeled 1987R.

Sources: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974–90.

TABLE 36.—NUMBER OF FAMILIES AND AVERAGE FAMILY SIZE, BY FAMILY TYPE, WEIGHTED BY FAMILIES, 1973, 1979, AND 1989

Family type and year	Persons per family	Number of families (thousands)
All families:		
1973	2.87	73,166
1979	2.59	84,229
1989	2.40	101,663
All families with children:		
1973	4.35	31,098
1979	4.09	32,166
1989	3.91	34,768
Married couples with children:		
1973	4.42	24,798
1979	4.23	24,166
1989	4.10	24,378
Single mothers with children:		
1973	3.50	4,126
1979	3.24	5,650
1989	3.05	7,123
Nonelderly childless units:		
1973	1.76	28,183
1979	1.68	35,730
1989	1.63	46,467
Nonelderly childless families:		
1973	2.32	16,363
1979	2.35	17,931
1989	2.38	21,257
Nonelderly unrelated individuals:		
1973	1.00	11,820
1979	1.00	17,799
1989	1.00	25,210
Elderly childless units		
1973	1.64	13,884
1979	1.62	16,331
1989	1.61	20,428
Elderly childless families:		
1973	2.17	7,590
1979	2.16	8,676
1989	2.17	10,600
Elderly unrelated individuals:		
1973	1.00	6,294
1979	1.00	7,655
1989	1.00	9,828

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

Results for specific family types: Posttax cash incomes plus food and housing assistance

A family's economic well-being is determined not only by its pretax cash income, but also by the amount of any noncash income it receives. Analyses that ignore noncash benefits—whether received from employers in the form of fringe benefits or through social welfare transfer programs—understate how well-off families are. The understatement has grown over time, moreover, because in-kind income has increased as a share of personal income. Employer-provided benefits and government transfers increased from 11 percent of personal income in 1970 to about 18 percent in 1984.

Whereas the omission of noncash income understates economic well-being for most families, using a pretax measure of income overstates it. Both income and payroll taxes reduce disposable income, so that posttax income would provide a better measure of the resources available to families to meet their needs. Taking taxes into account is also important for assessing income trends over time. Between 1973 and 1987, Social Security tax rates increased by over 20 percent, and the maximum amount of earnings subject to the tax increased by nearly 60 percent in real terms. Over the same period, the percentage of income paid in Federal income taxes fluctuated between 13 percent and nearly 17 percent, with a generally upward trend until the 1981 tax reduction.

Table 37 presents posttax income plus food and housing benefits as a fraction of poverty (that is, adjusted for family size). This concept, referred to subsequently as posttax AFI, is defined as family cash income minus Federal payroll and income taxes plus the estimated cash value of food and housing benefits.[13]

The noncash income included in this study comprises the cash value of food stamps, school lunches, and housing benefits. These data are available only for 1979 and later years, however, as the Bureau of the Census did not collect this informatioan until then. Similar information about the value of Medicaid and Medicare is also available, but the family-level data needed to allocate employer-provided health insurance benefits are not. The value of Medicaid and Medicare benefits is therefore excluded to avoid skewing the distribution of income toward low-income families.

Changes in economic well-being between 1979 and 1989 using the posttax AFI measure are shown in table 37 for six family types and four aggregates. For comparison purposes, the table also shows changes in pretax AFI between 1979 and 1989 (reproduced from table 30).

Among all families, the changes in the posttax AFI and pretax AFI measures are similar. On average, posttax AFI rose 11.6 percent between 1979 and 1989, compared with 11.8 percent for pretax AFI. For the lowest quintile, posttax AFI declined slightly less than pretax AFI between 1979 and 1989, 2.1 percent compared with 4.3 percent. For the highest quintile, posttax AFI rose by slightly more during this period: 20.4 percent compared with 19.6 percent.

---

[13] A more complete distribution of the change in tax burdens by family type and income quintile is shown in a separate analysis in appendix J.

There are large differences between the two measures for some income quintile and family types, most notably single mothers with children. On a pretax AFI basis, the lowest quintile for single mothers with children experienced a 22.9 percent income drop between 1979 and 1989. Taking taxes and food and housing assistance into account, however, reduces the drop to 5.2 percent.

Table 38 groups families according to the age of the head and presents changes in pretax AFI between 1973 and 1989 and changes in posttax AFI between 1979 and 1989. The most significant result is that income declines are concentrated among families in which the head is under age 35. Among all families whose head is under age 35, pretax AFI declined 28.2 percent between 1973 and 1989 for the lowest quintile and 23.5 percent between 1979 and 1989. Measured as posttax AFI, the decline was 14.6 percent between 1979 and 1989. Among families with children headed by a person under age 35, posttax AFI decreased for the three lowest quintiles.

Both pretax and posttax AFI of families headed by a person 65 or older increased during the periods shown. Among all such families, pretax AFI was 31.8 percent higher in 1989 than in 1973; posttax AFI was 20.0 percent higher in 1989 than in 1979. (The same caution should be used when interpreting changes in family types.)

Interpreting income changes by age requires particular care because families move into new age groups as time passes. A person aged 32 in 1979, for example, was 42 in 1989 and therefore in a new age grouping. Table 38 thus shows how families with young heads in 1989 fared in comparison with comparable families in 1979; it does not show changes in the incomes of families whose heads were under age 35 in 1979. (The same caution should be used when interpreting changes in family types.)

Tables 39 through 42 group families according to the race of the head and present changes in pretax AFI between 1973 and 1989 and changes in posttax AFI between 1979 and 1989 for different family types. For each family types shown in these tables, income gains were larger for families headed by a nonwhite person than families headed by a white. Between 1973 an 1979, pretax AFI rose 32.0 percent among all families headed by a nonwhite person, compared with 20.7 percent among families headed by a white person (see table 39). Between 1979 and 1989, posttax AFI rose 16.4 percent among families with a nonwhite head, compared with 11.9 percent among families whose head was white.

Although families with a nonwhite head experienced larger income gains, their income levels—both pretax AFI and posttax AFI—were much lower in each year. In 1989, for example, the average pre-tax for all families with a nonwhite head was 282 percent of poverty, compared with 418 percent of poverty for those whose head was white. The corresponding posttax numbers are 248 percent and 351 percent, respectively.

TABLE 37.—POST-TAX INCOME INCLUDING FOOD AND HOUSING BENEFITS AS A FRACTION OF POVERTY, BY FAMILY TYPE, WEIGHTED BY PERSONS, 1979 AND 1989

Family type and quintile	Post-tax income			Percent change in cash income, 1979–89
	1979	1989	Percent change	
All families:				
Lowest	0.96	0.93	−2.1	−4.3
Second	1.89	1.90	0.5	1.3
Middle	2.67	2.84	6.4	6.7
Fourth	3.63	4.01	10.6	10.5
Highest	5.85	7.04	20.4	19.6
Average	3.00	3.35	11.6	11.8
All families with children:				
Lowest	0.93	0.87	−6.2	−11.9
Second	1.79	1.72	−3.9	−4.2
Middle	2.46	2.53	2.9	3.3
Fourth	3.24	3.49	7.8	7.6
Highest	4.94	5.80	17.4	17.1
Average	2.67	2.88	7.9	8.0
Married couples with children:				
Lowest	1.16	1.14	−1.8	−2.9
Second	2.02	2.05	1.3	2.2
Middle	2.67	2.85	6.8	7.1
Fourth	3.43	3.78	10.2	10.2
Highest	5.11	6.13	20.0	19.8
Average	2.88	3.19	10.9	11.2
Single mothers with children:				
Lowest	0.49	0.47	−5.2	−22.9
Second	0.96	0.89	−6.6	−13.8
Middle	1.32	1.28	−3.4	−6.1
Fourth	1.92	1.92	−0.4	0.6
Highest	3.21	3.60	12.0	13.5
Average	1.58	1.63	3.1	3.2
Nonelderly childless units:				
Lowest	1.17	1.12	−4.5	−3.9
Second	2.53	2.53	−0.2	0.9
Middle	3.56	3.72	4.3	4.2
Fourth	4.68	5.11	9.3	8.8
Highest	7.16	8.52	18.9	17.1
Average	3.82	4.20	9.9	9.6
Nonelderly childless families:				
Lowest	1.71	1.65	−3.6	−2.8
Second	3.09	3.15	2.0	2.5
Middle	4.06	4.34	7.0	6.3

TABLE 37.—POST-TAX INCOME INCLUDING FOOD AND HOUSING BENEFITS AS A FRACTION OF POVERTY, BY FAMILY TYPE, WEIGHTED BY PERSONS, 1979 AND 1989—Continued

Family type and quintile	Post-tax income			Percent change in cash income, 1979–89
	1979	1989	Percent change	
Fourth	5.10	5.71	11.9	11.1
Highest	7.59	9.10	20.0	17.9
Average	4.31	4.79	11.2	10.7
Nonelderly unrelated individuals:				
Lowest	0.62	0.61	−0.4	−0.4
Second	1.56	1.62	3.3	6.4
Middle	2.36	2.51	6.7	8.0
Fourth	3.27	3.62	10.7	10.6
Highest	5.45	6.55	20.2	19.3
Average	2.65	2.98	12.7	13.1
Elderly childless units:				
Lowest	0.88	1.00	13.9	13.4
Second	1.53	1.73	13.4	14.8
Middle	2.23	2.56	14.8	16.9
Fourth	3.20	3.74	17.1	19.1
Highest	5.82	7.25	24.5	26.0
Average	2.73	3.26	19.3	21.2
Elderly childless families:				
Lowest	1.08	1.21	12.1	13.5
Second	1.86	2.11	13.4	15.2
Middle	2.60	3.01	15.7	17.4
Fourth	3.57	4.22	18.1	20.3
Highest	6.21	7.93	27.8	29.4
Average	3.06	3.70	20.6	22.9
Elderly unrelated individuals:				
Lowest	0.68	0.79	16.2	13.6
Second	1.08	1.25	15.6	14.7
Middle	1.42	1.67	17.5	18.2
Fourth	2.06	2.41	17.1	20.2
Highest	4.27	4.92	15.2	15.5
Average	1.90	2.21	16.1	16.7

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 38.—FAMILY CASH INCOME AND POST-TAX FAMILY INCOME PLUS FOOD AND HOUSING BENEFITS, AS A FRACTION OF POVERTY, BY TYPE OF FAMILY, AGE OF HEAD, AND QUINTILE, WEIGHTED BY PERSONS, 1973, 1979, AND 1989

Age of head and quintile	Adjusted family income[1]					Post-tax income plus food and housing[2]		
				Percent change				Percent change
	1973	1979	1989	1973–89	1979–89	1979	1989	1979–89
All Families								
Family head under age 35:								
Lowest	0.83	0.78	0.59	−28.2	−23.5	0.86	0.73	−14.6
Second	1.83	1.86	1.62	−11.6	−12.9	1.70	1.51	−10.9
Middle	2.59	2.74	2.62	1.3	−4.2	2.36	2.27	−4.1
Fourth	3.48	3.78	3.82	9.7	1.2	3.15	3.21	1.8
Highest	5.77	6.19	6.90	19.5	11.4	4.91	5.50	12.1
Average	2.90	3.07	3.11	7.3	1.4	2.60	2.64	1.9
Family head age 35 to 49:								
Lowest	1.01	1.03	1.06	5.4	3.1	1.07	1.09	1.9
Second	2.10	2.32	2.51	19.3	8.3	2.06	2.19	6.6
Middle	2.96	3.29	3.71	25.3	12.6	2.81	3.14	11.7
Fourth	3.99	4.45	5.18	29.8	16.3	3.70	4.27	15.5
Highest	6.74	7.24	8.96	32.8	23.7	5.70	7.07	24.1
Average	3.36	3.67	4.28	27.4	16.8	3.07	3.55	15.9

TABLE 38.—FAMILY CASH INCOME AND POST-TAX FAMILY INCOME PLUS FOOD AND HOUSING BENEFITS, AS A FRACTION OF POVERTY, BY TYPE OF FAMILY, AGE OF HEAD, AND QUINTILE, WEIGHTED BY PERSONS, 1973, 1979, AND 1989—Continued

Age of head and quintile	Adjusted family income[1]					Post-tax income plus food and housing[2]		
	1973	1979	1989	Percent change		1979	1989	Percent change
				1973–89	1979–89			1979–89
Family head age 50 to 64:								
Lowest	1.09	1.12	1.12	3.1	0.2	1.12	1.13	0.6
Second	2.46	2.64	2.74	11.6	3.7	2.37	2.43	2.5
Middle	3.63	3.92	4.21	16.0	7.4	3.35	3.59	7.1
Fourth	4.99	5.46	6.05	21.2	10.9	4.49	5.01	11.4
Highest	8.32	9.03	10.88	30.7	20.4	7.00	8.54	22.1
Average	4.10	4.44	5.00	22.0	12.8	3.67	4.14	12.9
Family head age 65 and over:								
Lowest	0.74	0.81	0.92	24.3	14.0	0.86	0.97	13.6
Second	1.31	1.46	1.67	27.9	14.6	1.48	1.68	13.4
Middle	1.92	2.17	2.56	33.2	17.6	2.15	2.48	15.5
Fourth	2.92	3.23	3.88	33.2	20.4	3.07	3.62	18.1
Highest	6.31	6.57	8.36	32.4	27.1	5.62	7.04	25.3
Average	2.64	2.85	3.48	31.8	22.1	2.63	3.16	20.0
Families With Children								
Family head under age 35:								
Lowest	0.80	0.71	0.53	−33.9	−25.5	0.83	0.72	−13.6
Second	1.73	1.69	1.39	−19.5	−17.7	1.58	1.37	−13.4

TABLE 38.—FAMILY CASH INCOME AND POST-TAX FAMILY INCOME PLUS FOOD AND HOUSING BENEFITS, AS A FRACTION OF POVERTY, BY TYPE OF FAMILY, AGE OF HEAD, AND QUINTILE, WEIGHTED BY PERSONS, 1973, 1979, AND 1989—Continued

Age of head and quintile	Adjusted family income[1]					Post-tax income plus food and housing[2]		
	1973	1979	1989	Percent change		1979	1989	Percent change
				1973–89	1979–89			1979–89
Middle	2.43	2.49	2.28	−5.9	−8.2	2.17	2.02	−7.3
Fourth	3.18	3.37	3.32	4.4	−1.2	2.85	2.83	−0.6
Highest	4.96	5.25	5.62	13.2	7.0	4.26	4.59	7.9
Average	2.62	2.70	2.63	0.3	−2.7	2.34	2.31	−1.4
Family head age 35 and over:								
Lowest	0.95	0.94	0.94	−0.3	−0.1	1.01	1.02	0.6
Second	1.99	2.14	2.23	11.9	4.0	1.94	1.99	2.5
Middle	2.81	3.08	3.34	18.6	8.4	2.66	2.87	7.8
Fourth	3.78	4.14	4.61	22.2	11.3	3.48	3.86	11.1
Highest	6.14	6.57	7.87	28.3	19.7	5.25	6.30	20.0
Average	3.13	3.38	3.80	21.3	12.5	2.87	3.21	11.9

---

[1] Quintiles are defined on the basis of adjusted family income (cash only).

[2] Quintiles are defined on the basis of post-tax adjusted family income, including food and housing benefits.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

TABLE 39.—FAMILY CASH INCOME AND POST-TAX FAMILY INCOME PLUS FOOD AND HOUSING FOR ALL FAMILIES, AS A FRACTION OF POVERTY, BY RACE OF HEAD AND QUINTILE, WEIGHTED BY PERSONS, 1973, 1979, AND 1989

Race of head and quintile	Adjusted family income [1]					Post-tax income plus food and housing [2]	1979	
	1973	1979	1989	Percent change			1989	Percent change 1979–89
				1973–89	1979–89			
White:								
Lowest	1.04	1.05	1.01	−3.0	−3.7	1.06	1.04	−2.2
Second	2.11	2.25	2.29	8.5	1.7	2.04	2.06	1.1
Middle	2.99	3.24	3.47	16.3	7.1	2.81	3.00	6.9
Fourth	4.10	4.50	4.98	21.4	10.7	3.76	4.17	10.9
Highest	7.07	7.61	9.14	29.3	20.1	6.00	7.26	21.0
Average	3.46	3.73	4.18	20.7	12.0	3.13	3.51	11.9
Nonwhite:								
Lowest	0.49	0.49	0.45	−8.7	−7.1	0.65	0.65	0.1
Second	1.02	1.10	1.20	17.6	8.9	1.19	1.25	5.1
Middle	1.68	1.88	2.15	28.1	14.6	1.77	1.96	10.5
Fourth	2.58	2.96	3.51	36.3	18.6	2.60	3.02	16.5
Highest	4.91	5.43	6.78	38.1	25.1	4.44	5.51	24.2
Average	2.14	2.37	2.82	32.0	19.0	2.13	2.48	16.4

[1] Quintiles are defined on the basis of adjusted family income (cash only).

[2] Quintiles are defined on the basis of post-tax adjusted family income, including food and housing benefits.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

CHART 9. PERCENT CHANGE IN FAMILY CASH INCOME AS A FRACTION OF POVERTY BY QUINTILE, 1973–89

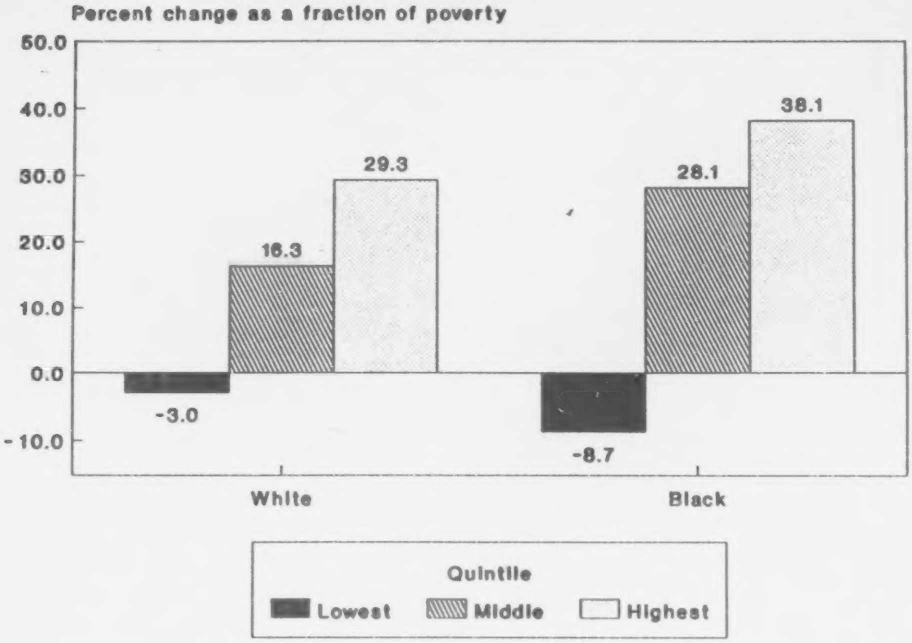


TABLE 40.—FAMILY CASH INCOME AND POST-TAX FAMILY INCOME PLUS FOOD AND HOUSING FOR FAMILIES WITH CHILDREN, AS A FRACTION OF POVERTY, BY RACE OF HEAD AND QUINTILE, WEIGHTED BY PERSONS, 1973, 1979, AND 1989

Race of head and quintile	Adjusted family income [1]					Post-tax income plus food and housing [2]		
	1973	1979	1989	Percent change		1979	1989	Percent change
				1973–89	1979–89			1979–89
White:								
Lowest	1.07	1.03	0.91	−14.8	−11.5	1.06	0.98	−7.1
Second	2.08	2.18	2.11	1.4	−3.2	1.95	1.89	−3.2
Middle	2.81	3.02	3.14	11.8	3.9	2.60	2.70	3.7
Fourth	3.69	4.01	4.32	17.2	7.7	3.36	3.63	7.9
Highest	5.89	6.33	7.43	26.1	17.4	5.07	5.97	17.8
Average	3.11	3.32	3.58	15.3	8.1	2.81	3.03	8.0
Nonwhite:								
Lowest	0.48	0.45	0.39	−18.6	−13.6	0.65	0.64	−2.3
Second	0.95	1.01	1.04	9.3	2.9	1.14	1.15	0.5
Middle	1.54	1.70	1.89	22.7	11.3	1.63	1.76	8.2
Fourth	2.34	2.66	3.12	33.4	17.1	2.36	2.70	14.3
Highest	4.32	4.77	5.92	37.0	24.1	3.94	4.86	23.3
Average	1.93	2.12	2.47	28.4	16.7	1.94	2.22	14.2

[1] Quintiles are defined on the basis of adjusted family income (cash only).

[2] Quintiles are defined on the basis of post-tax adjusted family income, including food and housing benefits.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

TABLE 41.—FAMILY CASH INCOME AND POST-TAX FAMILY INCOME PLUS FOOD AND HOUSING FOR NONELDERLY CHILDLESS UNITS, AFI BASIS, BY RACE OF HEAD AND QUINTILE, WEIGHTED BY PERSONS, 1973, 1979, AND 1989

Race of head and quintile	Adjusted family income [1]					Post-tax income plus food and housing [2]		
	1973	1979	1989	Percent change		1979	1989	Percent change
				1973–89	1979–89			1979–89
White:								
Lowest	1.35	1.38	1.34	−0.5	−2.7	1.28	1.23	−3.7
Second	2.99	3.08	3.13	4.8	1.6	2.67	2.68	0.6
Middle	4.25	4.45	4.65	9.5	4.5	3.69	3.87	4.8
Fourth	5.64	5.94	6.51	15.4	9.6	4.79	5.28	10.2
Highest	9.14	9.55	11.23	23.0	17.6	7.30	8.73	19.5
Average	4.67	4.88	5.37	15.0	10.1	3.95	4.36	10.4
Nonwhite:								
Lowest	0.61	0.62	0.64	4.8	2.2	0.67	0.68	2.5
Second	1.68	1.79	1.88	11.9	4.7	1.68	1.71	1.6
Middle	2.65	2.87	3.15	19.1	9.7	2.52	2.71	7.4
Fourth	3.88	4.16	4.74	22.4	14.2	3.47	3.94	13.5
Highest	6.65	7.07	8.45	27.0	19.5	5.61	6.72	19.8
Average	3.09	3.30	3.77	22.0	14.2	2.79	3.15	13.0

[1] Quintiles are defined on the basis of adjusted family income (cash only).

[2] Quintiles are defined on the basis of post-tax adjusted family income, including food and housing benefits.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

TABLE 42.—FAMILY CASH INCOME AND POST-TAX INCOME PLUS FOOD AND HOUSING FOR ELDERLY CHILDLESS UNITS, AFI BASIS, BY RACE OF HEAD AND QUINTILE, WEIGHTED BY PERSONS, 1973, 1979, AND 1989

Race of head and quintile	Adjusted family income [1]					Post-tax income plus food and housing [2]		
	1973	1979	1989	Percent change		1979	1989	Percent change 1979–89
				1973–89	1979–89			
White:								
Lowest...	0.80	0.88	1.00	25.6	13.7	0.92	1.04	13.7
Second...	1.40	1.58	1.81	29.7	15.0	1.59	1.81	13.7
Middle....	2.04	2.34	2.74	23.4	16.9	2.31	2.66	14.9
Fourth....	3.13	3.47	4.15	32.9	19.6	3.28	3.85	17.6
Highest..	6.71	7.01	8.81	31.3	25.7	5.94	7.39	24.4
Average..	2.81	3.06	3.71	31.6	21.2	2.81	3.35	19.4
Nonwhite:								
Lowest...	0.55	0.61	0.72	30.8	18.9	0.66	0.80	21.4
Second...	0.95	1.02	1.15	21.5	13.1	1.09	1.23	12.9
Middle....	1.26	1.45	1.72	36.1	18.3	1.50	1.73	15.2
Fourth....	1.93	2.27	2.78	43.8	22.1	2.22	2.64	18.7
Highest..	4.04	4.88	6.50	61.2	33.2	4.31	5.56	29.1
Average..	1.75	2.05	2.58	47.7	26.0	1.96	2.39	22.4

[1] Quintiles are defined on the basis of adjusted family income (cash only).

[2] Quintiles are defined on the basis of post-tax adjusted family income, including food and housing benefits.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1974, 1980, and 1990.

TRENDS IN INCOME, BENEFITS, AND TAXES, 1979–89

The trends in posttax incomes including noncash transfers (posttax AFI) discussed in the preceding section result from trends in the various components of income. Between 1979 and 1989, these components changed in quite different ways, with some rising sharply, some falling, and some rising for particular groups and falling for others. This section examines the trends in the following components of posttax AFI, all of which are expressed as fractions of poverty:

—*Earnings of the High Adult Male:* wage, salary, and self-employment income of the male family member aged 18 or older with the largest such income. This value is zero for families with no male members over age 18. It may be negative if losses were incurred in self-employment.

—*Earnings of the High Adult Female:* wage, salary, and self-employment income of the female family member aged 18 or older with the largest such income. This value is zero for families with no female members over age 18. It may be negative if losses were incurred in self-employment.

—*Total family earnings:* wage, salary, and self-employment income of all family members. This value is the sum of the earnings of the high adult male earner, the high adult female earner, and other earners (regardless of age).

—*Total private income:* total family earnings plus: income from private pensions, military or Government retirement, annuities, and other retirement programs; interest income, dividends, rents, royalties, and other income from investments; all other income from private sources, including child support and alimony payments and other forms of cash income from nongovernment sources.

—*Non-means tested cash transfers:* Social Security income, (payments from the Old Age, Survivors, and Disability Insurance program): Railroad Retirement income; and other government cash transfers that are not awarded on the basis of income level, including unemployment compensation, workers' compensation, veterans' benefits, and other transfers.

—*Means-tested cash transfers:* Government cash transfers that are awarded on the basis of income level, including Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and general assistance.

—*Pre-tax cash AFI:* total private income plus non-means tested cash transfers plus means-tested cash transfers.

—*Means-tested noncash transfers:* the cash equivalent of food and housing assistance provided to low-income families, including food stamps, school lunches, public housing, and housing subsidies.

—*Taxes:* federal individual income and employee payroll taxes.

—*Posttax AFI:* total pre-tax cash AFI plus means-tested noncash transfers minus taxes.

Sources of incomes for all families

Tables 43 through 48 show the posttax AFI derived from each of these sources in 1979 and 1989, as well as the absolute and percentage changes in those average amounts during that period. Averages are calculated separately for each income quintile, defined on the basis of posttax AFI, the income measure shown in the rightmost column of each table. The quintiles used in tables 43 through 48 are those for all families, not those for specific family types. Thus, for example, the lowest quintile for all families with children in table 44 includes families with children that were in the lowest quintile of all families, not the poorest 20 percent of families with children. (Tables 58 through 62 show comparable information for families divided into quintiles defined separately for each family type. These tables underlie the results shown in table 37.)

Private income.—Earnings account for more than half of posttax AFI for families in all income quintiles, and range from about half the poverty level for families in the lowest quintile to more than six times poverty for families with the highest incomes, as shown in column 3 of table 43. Between 1979 and 1989, however, earnings changed very little for the lowest and second quintiles while rising for other families: average earnings of the lowest quintile rose 1.0 percent, compared with a 16.7 percent increase in the earnings of the highest quintile.

These changes in earnings resulted from changes in the earnings of particular family members, changes which differed among both categories of earners and income quintiles. For high adult male earners, average adjusted earnings declined 5.1 percent between 1979 and 1989 for families in the lowest income quintile, but increased 9.5 percent for families in the top quintile. In contrast, the average adjusted earnings of high adult female earners rose for every quintile, but were up much more for families in the top three quintiles: these earnings increased by 12.8 percent for the lowest quintile, compared with a 45.8 percent gain for the highest quintile. The earnings of these women became much more important to the economic well-being of their families over the period, increasing from 24 percent to 29 percent of all earnings. The earnings of family members other than the high adult man and woman provided a much smaller share of family incomes and changed only slightly between 1979 and 1989.

Other forms of private income increased between 1979 and 1989 for families in every quintile, as reflected by the greater increase in total private income than in total family earnings. Among all families, other private income increased about 33 percent; for the lowest quintile, income from these sources increased about 5 percent compared with a 37 percent increase for families in the highest income quintile.

Transfers.—Overall, non-means-tested cash transfers were up 20 percent, while means-tested transfers, both cash and noncash, fell. Means-tested transfers fell more in percentage terms for families in the upper income quintiles than for those in the lowest quintile. In contrast, non-means-tested cash transfers declined by about 10 percent for the families in the lowest quintile, and rose by 41 percent for families in the highest quintile.

For all families, cash transfers from all sources (as a fraction of poverty) rose about 8 percent between 1979 and 1989. The increase was smaller than the increase in total private income, with the result that pre-tax cash AFI rose slightly less than total private income: 11.8 percent, compared with 12.1 percent. Cash transfers dropped by about 13 percent for families in the lowest quintile, from 33.9 percent of poverty to 29.5 percent. They increased by about 24 percent for families in the top quintile, from 20.5 percent of poverty to 25.5 percent.

The pattern in means-tested noncash transfers is just the opposite. Overall, such transfers declined very slightly, from about 2.5 percent of poverty to 2.4 percent. Means-tested noncash transfers rose just over 15 percent for families in the lowest quintile, from 8.1 percent of poverty to 9.4 percent. They declined significantly for families in every other quintile. For families in the top two quintiles, the decline is measured against a very small base, however, as these families receive very little income in the form of means-tested noncash transfers.

Overall, transfers reduced pretax income inequality in both 1979 and 1989, as families in the lowest quintile received relatively more transfer income (both cash and noncash). The effect was substantially smaller in 1989 than it was in 1979, however. Families in the lowest quintile received almost twice as much transfer income in 1979 as did families in the highest quintile; in 1989, they received about one and a half times as much.

Taxes.—Between 1979 and 1989, average adjusted individual federal income taxes and the employees' share of the payroll tax changed differently among income quintiles. For families in the lowest quintile, taxes fell almost 13 percent, from 3.4 percent of poverty to 3.0 percent of poverty. Taxes rose for every other quintile, with the increase ranging from 4.4 percent for families in the second quintile to 16.4 percent for families in the highest quintile. These taxes thus became more progressive during the period.

Sources of income by type of family

Incomes received from the various sources by different types of families generally experienced the same kinds of change between 1979 and 1989 as they did for all families. Tables 44 through 48 show the changes in average adjusted incomes by source for five types of families: all families with children, married couples with children, single mothers with children, nonelderly units without children, and elderly units without children. In these tables, quintiles are defined on the basis of post-tax income for all families, not those for the specific family type. Thus, a given quintile will generally not contain one-fifth of the families of a particular type. For example, in 1989, the lowest income quintile included 57 percent of single mothers with children, but less than 13 percent of nonelderly families without children. The distribution of families by income quintile is discussed further below.

Single Mothers with Children.—Of the individul family types, single mothers with children had the smallest increase in average income between 1979 and 1989. Overall, these families experienced a 10.7 percent increase in pretransfer income, composed of 10.4 percent rise in earnings and a slightly larger increase in income from other private sources (see table 46). This small increase was offset, however, by a 26 percent drop in cash transfer income.

The posttax AFI of single mothers with children in the bottom two quintiles fell. For those in the lowest quintile, income from nearly every source fell: earnings were down 5.8 percent; total pretransfer income down 3.0 percent; non-means-tested cash transfers were down 17.9 percent; and means-tested cash transfers, which might have been expected to increase as private income fell, declined 20.1 percent. Only means-tested noncash transfers rose (by 14.5 percent). The tax burden on single mothers with children in the lowest quintile also fell.

Single mothers in the highest income quintile had family earnings 18.4 percent higher in 1989 than in 1979 and total pretransfer income 20.8 percent higher. These gains were partially offset by a drop in cash transfer income, leaving the highest-income single mothers with an 18.8 percent rise in pre-tax AFI over the period.

Married Couples with Children.—Married couples with children fared better than single mothers, although incomes of families in the bottom two quintiles were essentially unchanged between 1979 and 1989, primarily because of declines in the earnings of fathers. In the lowest quintile, for example, average earnings of fathers dropped 3.4 percent during the period. Some of this loss was made up by much higher average earnings of mothers, but their earnings represented only a small share of total family earnings. Cash transfer incomes also declined for this quintile, but so did taxes.

For families in other quintiles, increases in the earnings of mothers were much greater, ranging from 48.3 percent in the second quintile to 58.3 percent in the top quintile. Most of these gains appear to be the result of higher earnings for mothers already working rather than of more mothers going to work: the average number of women workers in each married-couple family rose by just 8 percent between 1979 and 1989, as shown in table 54.[14] For all but the highest quintile, the increase in total family earnings was due almost entirely to the growth of mothers' earnings. Only in the fourth and highest quintiles did father's earnings increase, by 2.2 and 14.9 percent, respectively.

Non-means-tested cash transfers were down for families in the lowest quintile, and means-tested cash transfers fell for every quintile. Cash transfers were an important component of total income only for families in the lowest quintile, however; for them, cash transfers were about one-tenth of pre-tax AFI in both 1979 and 1989. The decline in their average cash transfer income was about 14 percent, offset slightly by a 2 percent increase in noncash transfer income.

Elderly Childless Units.—As a group, the elderly had the greatest income rise during the 1979–1989 period—19.3 percent—although average incomes increased only slightly for elderly units in the bottom two quintiles (see table 48). Among all elderly units, both earnings and non-means tested cash transfers rose. Means-tested transfers, both cash and noncash, decreased substantially, but these transfers represent a very small share of income among all elderly childless units.

---

[14] In this analysis, the number of earners is just the number of persons with wage and salary or self-employment income. This measure of work does not distinguish between persons who worked as little as 1 hour during the year and persons who worked full-time throughout the year. Thus although the average number of earners per family declined between 1979 and 1989, the amount of work effort may have increased, especially for women. Among all families, the average number of female earners per family was essentially unchanged between 1979 and 1989, but work experience data from the Bureau of Labor Statistics indicate there has been a significant shift toward full-time, full-year work among women.

For elderly units in the lowest quintile, non-means-tested cash transfers rose between 1979 and 1989. Because these transfers are by far the most important source of income for this group, pretax cash AFI rose slightly. Together with an increase in means-tested noncash transfer income, posttax AFI rose 1.6 percent for this group.

In contrast, the elderly in the highest quintile saw their incomes rise 21.4 percent. This increase reflects even larger increases in private income and non-means-tested cash transfer income, offset mainly by increased taxes.

Nonelderly Childless Units.—Nonelderly childless units experienced a 9.9 percent increase in average income between 1979 and 1989, primarily the result of higher earnings and other private income (see table 47). The earnings rise came almost entirely from increased average earnings among the highest earning women in these units; their earnings increased 27.4 percent.

Again, however, income changes varied sharply among quintiles. Nonelderly childless units in the lowest quintile had an increase in total family earnings of 3.4 percent, but cash transfers (which represented about one-third of pretax AFI) declined almost 18 percent. Means-tested noncash transfers increased 32.8 percent, but were more than offset by a 27.6 percent increase in taxes.

Incomes of units in the highest quintile increased 19.3 percent during the period, with most of the gain coming from higher earnings. Among these families, the earnings of highest earning women were up most sharply, 43.7 percent. As with married couples, the increase primarily reflects higher earnings, not an increase in the average number of working women per unit (see table 56).

Distribution of families by income quintile

The distribution of families among quintiles is shown in tables 49 through 51. Table 49 shows the number of people in families of each type among income quintiles for all families in 1979 and 1989. Tables 50 and 51 provide percentage distributions, the first by family type within each quintile and the second among quintiles for each type of family.

Tables 49 and 50 show that relatively fewer people lived in families with children in 1979 than in 1989. Although the number of people in such families increased from about 130 million to 135 million, the fraction of the population they account for fell from 60 percent in 1979 to 55 percent in 1989. The number of people living in nonelderly childless units, on the other hand, increased by 23 percent during the same period, from just over 60 million to 77 million, and the number living in elderly childless units increased 25 percent, from 27 million to 33 million. Combined with the slower growth in the number of people in families with children, the share of the population living in childless units rose from 40 percent in 1979 to 45 percent in 1989.

The data in table 51 indicate that single mothers with children are highly likely to be in the lower income quintiles: almost 80 percent were in the bottom two quintiles in 1989. In contrast, people living in nonelderly childless units are likely to be at the upper end of the income distribution: over 55 percent were in the top two quintiles in 1989. The elderly were distributed nearly uniformly among all five quintiles in 1989, and married couples with children were most likely to be in the middle three quintiles.

Family composition and adjusted incomes

The preferred measure of income used in this analysis is posttax family income plus in-kind transfers, adjusted for differences in family size. Using this measure makes interpretation of income changes more difficult, because adjusted family income is affected by changes in incomes from various sources, changes in taxes, and changes in family size. Table 57 examines the issue of family size and composition, showing the average number of family members by age and sex.

Among all families, average adjusted income increased 12 percent between 1979 and 1989. Part of this gain was the result, however, of a decline in average family size from 2.59 persons to 2.40 persons. Average family size decreased in every income quintile.

Most of the decline in family size came from families having fewer children. There was little change in the average size of either elderly or nonelderly childless units (recall table 36), but families with children had on average fewer children. More than half of the decline in family size is attributable to a smaller number of family members under age 18.

TABLE 43.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, ALL FAMILIES, QUINTILES DEFINED FOR ALL FAMILIES ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.328	0.165	0.508	0.569	0.209	0.130	0.908	0.081	−0.034	0.955
1989	.311	.186	.513	.577	.187	.108	.871	.094	−.030	.935
Change	−.017	.021	.005	.008	−.022	−.022	−.037	.013	.004	.020
Percent change	−5.1	12.8	1.0	1.4	−10.5	−17.2	−4.1	15.4	−12.6	−2.1
Second:										
1979	1.129	.438	1.625	1.722	.246	.047	2.065	.027	−.201	1.891
1989	1.019	.525	1.602	1.775	.287	.029	2.090	.020	−.210	1.901
Change	−.110	.087	−.023	.003	.041	−.019	.025	−.007	−.009	.010
Percent change	−9.8	20.0	−1.4	0.2	16.5	−39.4	1.2	−24.8	4.4	0.5
Middle::										
1979	1.845	.640	2.606	2.835	.212	.026	3.073	.011	−.411	2.673
1989	1.740	.847	2.707	3.006	.263	.011	3.279	.005	−.441	2.844
Change	−.105	.207	.101	.171	.051	−.015	.206	−.006	−.030	.171
Percent change	−5.7	32.3	3.9	6.0	24.0	−59.2	6.7	−56.4	7.2	6.4
Fourth:										
1979	2.644	.916	3.772	4.105	.182	.027	4.314	.006	−.695	3.625
1989	2.580	1.279	4.061	4.520	.242	.007	4.769	.002	−.762	4.009
Change	−.064	.363	.289	.415	.060	−.020	.455	−.004	−.067	.384

Percent change	−2.4	39.6	7.7	10.1	33.0	−73.3	10.5	−60.0	9.7	10.6
Highest:										
1979	4.427	1.379	6.196	7.166	.179	.026	7.371	.003	−1.529	5.845
1989	4.846	2.010	7.233	8.564	.252	.003	8.819	.001	−1.780	7.040
Change	.419	.631	1.037	1.398	.073	−.023	1.448	−.002	−.251	1.195
Percent change	9.5	45.8	16.7	19.5	40.7	−90.0	19.6	−60.0	16.4	20.4
Total:										
1979	2.074	.708	2.941	3.289	.205	.052	3.546	.025	−.574	2.997
1989	2.099	.970	3.223	3.688	.246	.031	3.966	.024	−.644	3.346
Change	.025	.262	.282	.399	.041	−.021	.420	−.001	−.070	.349
Percent change	1.2	36.9	9.6	12.1	20.0	−39.8	11.8	−2.4	12.3	11.6

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 44.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, ALL FAMILIES WITH CHILDREN, QUINTILES DEFINED FOR ALL FAMILIES ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.422	0.189	0.633	0.672	0.079	0.148	0.899	0.110	−0.040	0.969
1989	.384	.209	.615	.659	.066	.127	.852	.123	−.027	.948
Change	−.038	.020	−.018	−.013	−.013	−.021	−.047	.013	.013	−.021
Percent change	−9.0	10.3	−2.9	−1.9	−16.3	−14.3	−5.2	11.7	−33.3	−2.2
Second										
1979	1.381	.435	1.890	1.966	.087	.042	2.095	.030	−.231	1.894
1989	1.266	.574	1.911	2.004	.089	.026	2.119	.023	−.238	1.904
Change	−.116	.139	.021	.038	.002	−.016	.024	−.007	−.007	.010
Percent change	−8.4	31.8	1.1	1.9	2.0	−38.3	1.1	−23.0	2.9	0.5
Middle:										
1979	2.158	.597	2.898	3.014	.072	.024	3.110	.011	−.452	2.669
1989	2.092	.878	3.096	3.228	.079	.010	3.316	.007	−.485	2.838
Change	−.066	.281	.198	.214	.007	−.014	.206	−.004	−.033	.169
Percent change	−3.0	47.1	6.8	7.1	9.4	−60.4	6.6	−40.0	7.2	6.3
Fourth:										
1979	2.962	.855	4.052	4.240	.064	.020	4.324	.007	−.727	3.604
1989	2.967	1.298	4.462	4.686	.083	.006	4.776	.004	−.799	3.980
Change	.005	.443	.410	.446	.019	−.014	.452	−.003	−.072	.376

Percent change	0.2	51.8	10.1	10.5	30.0	−70.5	10.4	−45.7	9.9	10.4
Highest:										
1979	4.668	1.183	6.199	6.771	.063	.015	6.849	.006	−1.405	5.450
1989	5.277	1.860	7.393	8.125	.081	.003	8.208	.003	−1.651	6.561
Change	.609	.677	1.194	1.354	.018	−.012	1.359	−.003	−.246	1.111
Percent change	13.0	57.2	19.3	20.0	28.4	−83.3	19.8	−48.3	17.5	20.4
Total:										
1979	2.089	.599	2.834	2.998	.074	.053	3.125	.036	−.491	2.670
1989	2.082	.859	3.061	3.258	.079	.039	3.376	.037	−.532	2.881
Change	−.007	.260	.227	.260	.005	−.014	.251	.001	−.040	.211
Percent change	−0.4	43.5	8.0	8.7	7.0	−26.0	8.0	1.9	8.2	7.9

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 45.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, MARRIED COUPLES WITH CHILDREN, QUINTILES DEFINED FOR ALL FAMILIES ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.701	0.123	0.845	0.874	0.077	0.058	1.009	0.067	−0.056	1.020
1989	.678	.159	.851	.883	.063	.053	.999	.068	.048	1.020
Change	−.024	.036	.006	.009	−.015	−.005	−.010	.001	.008	−.001
Percent change	−3.4	29.4	.7	1.0	−18.8	−7.9	−1.0	1.9	−15.0	−.0
Second:										
1979	1.648	.290	1.995	2.049	.061	.022	2.132	0.020	−.251	1.901
1989	1.551	.430	2.028	2.093	.067	.014	2.173	.016	−.267	1.921
Change	−.097	.140	.033	.044	.006	−.009	.040	−.004	−.016	.020
Percent change	−5.9	48.3	1.6	2.1	9.0	−38.6	1.9	−22.0	6.5	1.0
Middle:										
1979	2.382	.481	2.979	3.066	.049	.017	3.132	.009	−.469	2.672
1989	2.355	.745	3.180	3.284	.055	.006	3.345	.005	−.503	2.847
Change	−.027	.264	.201	.218	.006	−.011	.213	−.004	−.034	.175
Percent change	−1.1	54.9	6.8	7.1	11.4	−64.1	6.8	−40.0	7.3	6.5
Fourth:										
1979	3.141	.790	4.129	4.286	.044	.015	4.345	.007	−743	3.609
1989	3.211	1.198	4.547	4.736	.057	.005	4.798	.004	−.819	3.983
Change	.070	.408	.418	.450	.013	−.010	.453	−.003	−.076	.374

Percent change	2.2	51.6	10.1	10.5	30.0	−68.7	10.4	−47.1	10.2	10.4
Highest:										
1979	4.810	1.144	6.276	6.800	.042	.013	6.855	.005	−1.421	5.439
1989	5.527	1.811	7.524	8.189	.056	.001	8.247	.003	−1.676	6.574
Change	.717	.667	1.257	1.389	.014	−.012	1.392	−.002	−.255	1.135
Percent change	14.9	58.3	20.1	20.4	33.1	−89.2	20.3	−42.0	17.9	20.9
Total:										
1979	2.498	.553	3.188	3.342	.054	.023	3.419	.020	−.563	2.876
1989	2.598	.850	3.541	3.731	.059	.014	3.804	.017	−.632	3.188
Change	.100	.297	.353	.389	.005	−.009	.385	−.003	−.069	.312
Percent change	4.0	53.8	11.1	11.6	9.8	−38.7	11.3	−16.0	12.3	10.9

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 46.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, SINGLE MOTHERS WITH CHILDREN, QUINTILES DEFINED FOR ALL FAMILIES ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.020	0.292	0.330	0.384	0.067	0.277	0.728	0.175	-0.016	0.887
1989	.011	.284	.311	.372	.055	.221	.649	.200	.001	.850
Change	-.009	-.008	-.019	-.012	-.012	-.056	-.079	.025	.017	-.037
Percent change	-45.5	-2.6	-5.8	-3.0	-17.9	-20.1	-10.9	14.5	-104.4	-4.2
Second:										
1979	.079	1.253	1.423	1.618	.170	.120	1.908	.081	-.140	1.849
1989	.056	1.372	1.497	1.733	.117	.059	1.909	.054	-.127	1.837
Change	-.023	.119	.074	.115	-.053	-.062	.001	-.027	.013	-.013
Percent change	-29.6	9.5	5.2	7.1	-31.1	-51.3	.1	-33.1	-9.4	-0.7
Middle:										
1979	.211	1.875	2.266	2.642	.212	.067	2.921	.028	-.318	2.631
1989	.161	2.257	2.581	2.968	.160	.019	3.147	.016	-.368	2.795
Change	-.050	.382	.315	.326	-.052	-.048	.226	-.012	-.049	.164
Percent change	-23.9	20.4	13.9	12.3	-24.3	-71.9	7.7	-44.3	15.6	6.2
Fourth:										
1979	.410	2.431	3.134	3.734	.247	.062	4.043	.019	-.523	3.539
1989	.295	3.220	3.829	4.362	.169	.015	4.546	.007	-.625	3.927
Change	-.115	.789	.695	.628	-.078	-.047	.503	-.012	-.102	.388

Percent change	−28.0	32.5	22.2	16.8	−31.5	−76.3	12.4	−62.6	19.6	11.0
Highest:										
1979	.457	3.594	4.471	6.213	.363	.049	6.625	.022	−1.014	5.633
1989	.249	4.629	5.295	7.506	.358	.004	7.868	.006	−1.247	6.627
Change	−.208	1.035	.824	1.293	−.005	−.045	1.243	−.016	−.233	.993
Percent change	−45.6	28.8	18.4	20.8	−1.5	−92.2	18.8	−74.1	22.9	17.6
Total:										
1979	.091	.905	1.076	1.268	.125	.198	1.591	.123	−.133	1.581
1989	.063	1.051	1.188	1.404	.095	.143	1.642	.129	−.140	1.631
Change	−.028	.146	.112	.136	−.030	−.055	.051	.006	−.007	.050
Percent change	−30.7	16.1	10.4	10.7	−23.7	−27.9	3.2	4.8	5.6	3.1

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 47.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, NONELDERLY CHILDLESS UNITS, QUINTILES DEFINED FOR ALL FAMILIES ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.288	0.221	0.516	0.616	0.146	0.096	0.858	0.029	−0.045	0.842
1989	.294	.234	.534	.633	.130	.076	.838	.039	−.057	.819
Change	.006	.013	.018	.017	−.017	−.020	−.020	.009	−.012	−.023
Percent change	2.1	5.9	3.4	2.7	−11.3	−21.3	−2.3	32.8	27.6	−2.7
Second:										
1979	.925	.716	1.679	1.882	.180	.051	2.113	.013	−.223	1.903
1989	.991	.701	1.749	1.963	.173	.030	2.166	.010	.264	1.912
Change	.066	−.015	.070	.081	−.007	−.021	.053	−.003	−.041	.009
Percent change	7.2	−2.2	4.1	4.3	−4.1	−41.0	2.5	−20.0	18.5	.5
Middle:										
1979	1.610	.944	2.660	2.909	.176	.033	3.118	.005	−.437	2.686
1989	1.663	1.076	2.896	3.199	.157	.013	3.368	.002	−.505	2.866
Change	.053	.132	.236	.290	−.019	−.021	.250	−.003	−.068	.180
Percent change	3.3	13.9	8.9	10.0	−11.0	−62.1	8.0	−60.0	15.5	6.7
Fourth:										
1979	2.580	1.164	3.957	4.254	.132	.036	4.422	.002	−.754	3.670
1989	2.609	1.508	4.363	4.750	.136	.009	4.895	.001	−.842	4.053
Change	.029	.344	.406	.496	.004	−.027	.473	−.001	−.088	.383

Percent change	1.1	29.6	10.3	11.7	3.1	−75.0	10.7	−60.0	11.7	10.4
Highest:										
1979	4.716	1.646	6.821	7.647	.098	.027	7.772	.001	−1.697	6.076
1989	5.173	2.365	8.035	9.069	.119	.002	9.191	.000	−1.943	7.248
Change	.457	.719	1.214	1.422	.021	−.025	1.419	−.001	−.245	1.172
Percent change	9.7	43.7	17.8	18.6	21.4	−91.5	18.3	−80.0	14.5	19.3
Total:										
1979	2.716	1.132	4.086	4.533	.134	.042	4.709	.007	−.895	3.821
1989	2.779	1.442	4.478	5.006	.138	.019	5.163	.007	−.970	4.200
Change	.063	.310	.392	.473	.004	−.023	.454	.000	−.075	.379
Percent change	2.3	27.4	9.6	10.4	3.1	−54.8	9.6	1.4	8.4	9.9

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 48.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, ELDERLY CHILDLESS UNITS, QUINTILES DEFINED FOR ALL FAMILIES ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.03	0.024	0.044	0.147	0.742	0.103	0.992	0.031	−0.003	1.020
1989	.019	.024	.043	.142	.791	.068	1.000	.041	−.005	1.036
Change	−.004	−.000	−.001	−.005	.048	−.035	.008	.010	−.002	.016
Percent change	−17.4	−1.7	−1.8	−3.1	6.5	−34.5	0.8	31.3	53.3	1.6
Second:										
1979	.135	.108	.246	.677	1.116	.062	1.855	0.026	−.020	1.861
1989	.104	.099	.210	.634	1.206	.037	1.877	.023	−.027	1.874
Change	−.032	−.009	−.036	−.043	.090	−.025	.022	−.003	−.007	.012
Percent change	−23.3	−8.7	−14.8	−6.3	8.1	−40.8	1.2	−11.2	35.0	0.7
Middle:										
1979	.365	.284	.673	1.654	1.159	.029	2.752	.015	−.099	2.668
1989	.297	.242	.560	1.608	1.313	.012	2.934	.002	−.112	2.824
Change	−.068	−.042	−.113	.044	.154	−.017	.182	−.013	−.013	.156
Percent change	−18.7	−14.8	−16.8	2.8	13.3	−59.0	6.6	−86.7	13.4	5.8
Fourth:										
1979	.750	.461	1.274	2.696	1.137	.040	3.873	.007	−.274	3.606
1989	.700	.495	1.286	3.048	1.301	.008	4.357	.001	−.348	4.010
Change	−.050	.034	.012	.352	.164	−.032	.484	−.006	−.073	.404

Percent change	−6.7	7.4	0.9	13.0	14.4	−80.5	12.5	−91.4	26.8	11.2
Highest:										
1979	2.045	.785	3.036	6.254	1.033	.061	7.348	.001	−1.155	6.194
1989	2.219	.927	3.354	7.661	1.308	.005	8.974	.000	−1.454	7.521
Change	.173	.142	.317	1.407	.275	−.056	1.626	−.001	−.299	1.327
Percent change	8.5	18.1	10.5	22.5	26.7	−92.5	22.1	−60.1	25.9	21.4
Total:										
1979	.548	.278	.873	1.895	1.006	.065	2.966	.019	−.254	2.731
1989	.606	.327	.992	2.396	1.171	.028	3.595	.015	−.351	3.258
Change	.058	.049	.119	.501	.164	−.037	.629	−.004	−.097	.527
Percent change	10.6	17.7	13.7	26.4	16.4	−57.1	21.2	−21.6	38.2	19.3

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 49.—DISTRIBUTION OF PEOPLE AMONG QUINTILES FOR ALL FAMILIES, QUINTILES BASED ON POST-TAX INCOME PLUS FOOD AND HOUSING ASSISTANCE DIVIDED BY THE POVERTY THRESHOLD, BY FAMILY TYPE 1979 AND 1989

[In thousands]

Family type	Income quintile					
	Lowest	Second	Middle	Fourth	Highest	Total
Distribution in 1979:						
All families	43,568	43,546	43,538	43,540	43,525	217,718
All families with children	28,212	30,015	29,271	26,033	16,896	130,426
Married couples with children	15,315	23,177	24,665	22,833	15,328	101,318
Single mothers with children	10,265	4,091	2,264	1,186	325	18,132
Nonelderly childless units	7,683	7,449	9,582	13,585	22,216	60,514
Elderly childless units	7,674	6,083	4,685	3,923	4,413	26,778
Distribution in 1989:						
All families	49,168	49,170	49,169	49,168	49,172	245,846
All families with children	31,832	30,412	29,539	26,305	17,293	135,381
Married couples with children	15,587	22,200	23,841	22,388	15,454	99,471
Single mothers with children	12,307	4,638	2,663	1,452	443	21,504
Nonelderly childless units	10,002	10,873	13,126	17,194	25,829	77,025
Elderly childless units	7,333	7,885	6,504	5,669	6,049	33,440

Note.—Detail may not add to totals because of rounding.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 50.—PERCENTAGE DISTRIBUTION OF PEOPLE WITHIN QUINTILES FOR ALL FAMILIES, QUINTILES BASED ON POST-TAX INCOME PLUS FOOD AND HOUSING ASSISTANCE DIVIDED BY THE POVERTY THRESHOLD, BY FAMILY TYPE 1979 AND 1989

[In percent]

Family type	Income quintile					
	Lowest	Second	Middle	Fourth	Highest	Total
Distribution in 1979:						
All families	100.0	100.0	100.0	100.0	100.0	100.0
All families with children	64.8	68.9	67.2	59.8	38.8	59.9
Married couples with children	35.2	53.2	56.7	52.4	35.2	46.5
Single mothers with children	23.6	9.4	5.2	2.7	0.7	8.3
Nonelderly childless units	17.6	17.1	22.0	31.2	51.0	27.8
Elderly childless units	17.6	14.0	10.8	9.0	10.1	12.3
Distribution in 1989:						
All families	100.0	100.0	100.0	100.0	100.0	100.0
All families with children	64.7	61.9	60.1	53.5	35.2	55.1
Married couples with children	31.7	45.1	48.5	45.5	31.4	40.5
Single mothers with children	25.0	9.4	5.4	3.0	0.9	8.7
Nonelderly childless units	20.3	22.1	26.7	35.0	52.5	31.3
Elderly childless units	14.9	16.0	13.2	11.5	12.3	13.6

Note.—Detail may not add to totals because of rounding. The left-most table entry for all families with children is interpreted as follows: in 1979, 64.8 percent of all people with adjusted family incomes in the lowest quintile were in families with children.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 51.—PERCENTAGE DISTRIBUTION OF PEOPLE AMONG QUINTILES FOR ALL FAMILIES, QUINTILES BASED ON POST-TAX INCOME PLUS FOOD AND HOUSING ASSISTANCE DIVIDED BY THE POVERTY THRESHOLD, BY FAMILY TYPE 1979 AND 1989

[In percent]

Family type	Income quintile					
	Lowest	Second	Middle	Fourth	Highest	Total
Distribution in 1979:						
All families	20.0	20.0	20.0	20.0	20.0	100.0
All families with children	21.6	23.0	22.4	20.0	13.0	100.0
Married couples with children	15.1	22.9	24.3	22.5	15.1	100.0
Single mothers with children	56.6	22.6	12.5	6.5	1.8	100.0
Nonelderly childless units	12.7	12.3	15.8	22.4	36.7	100.0
Elderly childless units	28.7	22.7	17.5	14.6	16.5	100.0
Distribution in 1989:						
All families	20.0	20.0	20.0	20.0	20.0	100.0
All families with children	23.5	22.5	21.8	19.4	12.8	100.0
Married couples with children	15.7	22.3	24.0	22.5	15.5	100.0
Single mothers with children	57.2	21.6	12.4	6.8	2.1	100.0
Nonelderly childless units	13.0	14.1	17.0	22.3	33.5	100.0
Elderly childless units	21.9	23.6	19.4	17.0	18.1	100.0

Note.—Detail may not add to totals because of rounding. The left-most table entry for all families with children is interpreted as follows: in 1979, 21.6 percent of all people in families with children had adjusted family incomes in the lowest quintile.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 52.—AVERAGE NUMBER OF EARNERS FOR ALL FAMILIES, BY SEX AND INCOME QUINTILE, QUINTILES BASED ON POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE FOR ALL FAMILIES, WEIGHTED BY FAMILIES, 1979 AND 1989

[In persons]

Income quintile and year	Male earners	Female earners	Total earners
Lowest:			
1979	0.34	0.32	0.66
1989	.33	.34	.67
Change	−.01	.02	.00
Second:			
1979	.61	.54	1.14
1989	.56	.52	1.08
Change	−.05	−.02	.07
Middle:			
1979	.80	.64	1.44
1989	.74	.65	1.38
Change	−.07	.01	−.06
Fourth:			
1979	.96	.73	1.68
1989	.85	.73	1.58
Change	−.11	.00	−.11
Highest:			
1979	1.06	.74	1.79
1989	.97	.76	1.73
Change	−.09	.02	−.06
Average:			
1979	.75	.59	1.34
1989	.69	.60	1.29
Change	−.07	.01	−.06

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 53.—AVERAGE NUMBER OF EARNERS FOR ALL FAMILIES WITH CHILDREN, BY SEX AND INCOME QUINTILE, QUINTILES BASED ON POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE FOR ALL FAMILIES, WEIGHTED BY FAMILIES, 1979 AND 1989

[In persons]

Income quintile and year	Male earners	Female earners	Total earners
Lowest:			
1979	0.57	0.54	1.11
1989	.46	.52	.98
Change	—.11	—.02	—.12
Second:			
1979	.92	.76	1.68
1989	.81	.80	1.62
Change	—.11	.04	—.07
Middle:			
1979	1.08	.83	1.91
1989	1.00	.89	1.89
Change	—.08	.06	—.02
Fourth:			
1979	1.20	.93	2.13
1989	1.09	.98	2.07
Change	—.11	.06	—.06
Highest:			
1979	1.30	.97	2.27
1989	1.15	1.00	2.16
Change	—.15	.04	—.11
Average:			
1979	1.01	.81	1.82
1989	0.90	.84	1.74
Change	—.11	.03	—.08

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 54.—AVERAGE NUMBER OF EARNERS FOR MARRIED COUPLES WITH CHILDREN, BY SEX AND INCOME QUINTILE, QUINTILES BASED ON POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE FOR ALL FAMILIES, WEIGHTED BY FAMILIES, 1979 AND 1989

[In persons]

Income quintile and year	Male earners	Female earners	Total earners
Lowest:			
1979	1.02	0.55	1.57
1989	.94	0.59	1.52
Change	−.08	0.04	−0.04
Second:			
1979	1.13	0.72	1.85
1989	1.08	0.82	1.90
Change	−.05	0.10	0.05
Middle:			
1979	1.20	0.80	1.99
1989	1.14	0.89	2.03
Change	−0.06	0.09	0.04
Fourth:			
1979	1.26	0.94	2.20
1989	1.16	0.98	2.14
Change	−0.10	0.04	−0.06
Highest:			
1979	1.33	0.96	2.29
1989	1.18	0.99	2.18
Change	−0.14	0.03	−0.12
Average:			
1979	1.19	0.79	1.98
1989	1.10	0.85	1.95
Change	−0.09	0.06	−0.03

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 55.—AVERAGE NUMBER OF EARNERS FOR SINGLE MOTHERS WITH CHILDREN, BY SEX AND INCOME QUINTILE, QUINTILES BASED ON POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE FOR ALL FAMILIES, WEIGHTED BY FAMILIES, 1979 AND 1989

[In persons]

Income quintile and year	Male earners	Female earners	Total earners
Lowest:			
1979	0.07	0.45	0.52
1989	.05	.41	.45
Change	−.02	−.05	−.06
Second:			
1979	.11	.58	.69
1989	.07	.55	.63
Change	−.04	−.02	−.06
Middle:			
1979	.16	.84	1.00
1989	.10	.90	1.01
Change	−.06	.06	.00
Fourth:			
1979	.23	1.11	1.34
1989	.13	1.11	1.24
Change	−.10	.00	−.10
Highest:			
1979	.38	1.21	1.59
1989	.28	1.22	1.49
Change	−.10	.01	−.10
Average:			
1979	.20	.86	1.06
1989	.13	.84	.96
Change	−.07	−.02	−.10

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 56.—AVERAGE NUMBER OF EARNERS FOR NONELDERLY CHILDLESS UNITS, BY SEX AND INCOME QUINTILE, QUINTILES BASED ON POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE FOR ALL FAMILIES, WEIGHTED BY FAMILIES, 1979 AND 1989

[In persons]

Income quintile and year	Male earners	Female earners	Total earners
Lowest:			
1979	0.40	0.37	0.77
1989	.39	.36	.75
Change	—.01	—.01	—.02
Second:			
1979	.60	.54	1.14
1989	.63	.52	1.15
Change	.03	—.02	.01
Middle:			
1979	.79	.61	1.40
1989	.76	.62	1.38
Change	—.03	.01	—.02
Fourth:			
1979	.96	.68	1.63
1989	.90	.72	1.62
Change	—.05	.04	—.01
Highest:			
1979	1.08	.74	1.82
1989	1.03	.78	1.81
Change	—.05	.05	—.01
Average:			
1979	.77	.59	1.35
1989	.74	.60	1.34
Change	—.02	.02	—.01

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 57.—AVERAGE NUMBER OF FAMILY MEMBERS FOR ALL FAMILIES, BY AGE, SEX, AND INCOME QUINTILE, QUINTILES BASED ON POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY FAMILIES, 1979 AND 1989

Income quintile and year	Under age 18			Ages 18 through 64			Age 65 and over			All ages		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Lowest:												
1979	0.45	0.43	0.88	0.42	0.64	1.06	0.12	0.26	0.39	0.99	1.34	2.33
1989	.44	.42	.86	.45	.65	1.11	.10	.22	.31	.98	1.29	2.28
Change	−.01	−.01	−.02	.03	.01	.04	−.03	−.05	−.07	−.01	−.04	−.05
Second:												
1979	.49	.46	.94	.62	.75	1.37	.15	.21	.35	1.25	1.42	2.67
1989	.38	.36	.74	.60	.68	1.28	.14	.22	.36	1.11	1.27	2.38
Change	−.11	−.09	−.20	−.02	−.07	−.09	−.01	.01	.01	−.14	−.15	−.29
Middle:												
1979	.47	.41	.88	.78	.84	1.62	.12	.14	.26	1.37	1.39	2.76
1989	.37	.34	.72	.74	.78	1.52	.13	.16	.30	1.24	1.29	2.53
Change	−.09	−.07	−.16	−.04	−.06	−.10	.02	.02	.04	−.12	−.11	−.23
Fourth:												
1979	.35	.32	.68	.92	.89	1.80	.09	.11	.20	1.36	1.32	2.68
1989	.29	.28	.56	.84	.83	1.67	.11	.13	.24	1.24	1.24	2.47
Change	−.07	−.05	−.11	−.08	−.06	−.13	.02	.02	.04	−.13	−.08	−.21

Highest:												
1979	.19	.18	.37	1.01	.91	1.92	.10	.11	.21	1.29	1.20	2.50
1989	.17	.17	.33	.93	.87	1.80	.12	.12	.23	1.22	1.15	2.37
Change	−.02	−.02	−.04	−.07	−.05	−.12	.02	.01	.03	−.08	−.05	−.13
Total:												
1979	.39	.36	.75	.75	.81	1.55	.12	.17	.28	1.25	1.33	2.59
1989	.33	.31	.64	.71	.76	1.47	.12	.17	.29	1.16	1.25	2.40
Change	−.06	−.05	−.11	−.04	−.04	−.08	.00	.00	.01	−.09	−.09	−.18

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 58.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, ALL FAMILIES WITH CHILDREN, QUINTILES DEFINED FOR SPECIFIC FAMILY TYPE ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pretax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Nonmeans tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.384	.0177	.0582	0.618	0.079	0.153	0.850	0.114	−0.035	0.929
1989	.315	.179	.512	.552	.063	.137	.752	.134	−.015	.871
Change	−.070	.002	−.070	−.066	−.016	−.016	−.098	.020	.020	−.058
Percent change	−18.1	1.2	−12.0	−10.6	−20.6	−10.2	−11.5	17.1	−58.3	−6.2
Second:										
1979	1.265	.413	1.744	1.817	.087	.048	1.952	.035	−.201	1.786
1989	1.084	.507	1.654	1.741	.088	.037	−1.867	.034	−.184	1.716
Change	−.181	.094	−.090	−.076	.001	−.011	−.085	−.001	.017	−.070
Percent change	−14.3	22.7	−5.2	−4.2	1.3	−22.1	−4.4	−3.1	−8.3	−3.9
Middle:										
1979	1.961	.551	2.632	2.738	.077	.025	2.840	.014	−.392	2.462
1989	1.834	.774	2.722	2.839	.083	.011	2.932	.008	−.408	2.533
Change	−.127	.223	.090	.101	.005	−.014	.092	−.006	−.016	.071
Percent change	−6.5	40.5	3.4	3.7	7.1	−56.8	3.2	−40.7	4.0	2.9
Fourth:										
1979	2.652	.744	3.599	3.754	.067	.022	3.843	.009	−.614	3.238
1989	2.603	1.113	3.874	4.048	.085	.007	4.140	.004	−.654	3.490
Change	−.049	.369	.275	.294	.018	−.015	.297	−.005	−.040	.252

Percent change	−1.8	49.6	7.6	7.8	27.3	−67.3	7.7	−51.1	6.6	7.8
Highest:										
1979	4.186	1.110	5.615	6.063	.063	.014	6.140	.006	−1.210	4.936
1989	4.571	1.723	6.540	7.108	.077	.003	7.188	.003	−1.396	5.795
Change	.385	.613	.925	1.045	.014	−.011	1.048	−.003	−.186	.859
Percent change	9.2	55.2	16.5	17.2	22.5	−77.9	17.1	−45.0	15.4	17.4
Total:										
1979	2.089	.599	2.834	2.998	.074	.053	3.125	.036	−.491	2.670
1989	2.082	.859	3.061	3.258	.079	.039	3.376	.037	−.532	2.881
Change	−.007	.260	.227	.260	.005	−.014	.251	.001	−.041	.211
Percent change	−.4	43.5	8.0	8.7	7.0	−26.0	8.0	1.9	8.2	7.9

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 59.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, MARRIED COUPLES WITH CHILDREN, QUINTILES DEFINED FOR SPECIFIC FAMILY TYPE ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.854	0.149	1.029	1.060	0.074	0.050	1.184	0.058	−0.084	1.158
1989	.788	.194	1.000	1.039	.064	.047	1.150	.060	−.073	1.137
Change	−.066	.045	−.029	−.021	−.010	−.003	−.034	.002	.011	−.021
Percent change	−7.8	30.5	−2.8	−2.0	−13.9	−5.4	−2.9	4.0	−13.0	−1.8
Second:										
1979	1.774	.315	2.151	2.209	.058	.021	2.288	.017	−.285	2.020
1989	1.674	.468	2.196	2.262	.064	.010	2.337	.012	−.302	2.046
Change	−.100	.153	.045	.053	.006	−.011	.049	−.005	−.017	.026
Percent change	−5.6	48.5	2.1	2.4	10.9	−51.9	2.1	−31.8	6.1	1.3
Middle:										
1979	2.370	.480	2.963	3.054	.051	.017	3.122	.010	−467	2.665
1989	2.360	.742	3.180	3.285	.053	.007	3.345	.005	−.503	2.847
Change	−.010	.262	.217	.231	.002	−.010	.223	−.005	−.036	.182
Percent change	−.4	54.5	7.3	7.6	4.1	−60.6	7.1	−48.0	7.7	6.8
Fourth:										
1979	2.997	.716	3.904	4.045	.044	.017	4.106	.008	−.687	3.427
1989	3.044	1.117	4.291	4.458	.061	.005	4.524	.004	−.752	3.776
Change	.047	.401	.387	.413	.017	−.012	.418	−.004	−.064	.349

Percent change	1.6	56.0	9.9	10.2	39.1	−72.4	10.2	−52.5	9.4	10.2
Highest:										
1979	4.497	1.107	5.895	6.343	.044	.012	6.399	.006	−1.294	5.111
1989	5.123	1.731	7.035	7.607	.054	.002	7.663	.003	−1.531	6.135
Change	.626	.624	1.140	1.264	.010	−.010	1.264	−.003	−.237	1.024
Percent change	13.9	56.4	19.3	19.9	23.0	−84.2	19.8	−50.0	18.3	20.0
Total:										
1979	2.498	.553	3.188	3.342	.054	.023	3.419	.020	−.563	2.876
1989	2.598	.850	3.541	3.731	.059	.014	3.804	.017	−.632	3.188
Change	.100	.297	.353	.389	.005	−.009	.385	−.003	−.069	.312
Percent change	4.0	53.8	11.1	11.6	9.8	−38.7	11.3	−16.0	12.3	10.9

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 60.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, SINGLE MOTHERS WITH CHILDREN, QUINTILES DEFINED FOR SPECIFIC FAMILY TYPE ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.007	0.098	0.112	0.149	0.038	0.172	0.359	0.137	-0.005	0.491
1989	.004	.086	.095	.132	.025	.140	.296	.166	.004	.466
Change	-.003	-.012	-.017	-.017	-.013	-.032	-.063	.028	.009	-.025
Percent change	-48.6	-12.4	-15.1	-11.7	-33.7	-18.8	-17.4	20.8	-176.0	-5.2
Second:										
1979	.012	.240	.271	.318	.060	.377	.755	.213	-.011	.957
1989	.009	.211	.232	.277	.058	.308	.643	.246	.005	.894
Change	-.003	-.029	-.039	-.041	-.002	-.069	-.112	.033	.016	-.063
Percent change	-27.5	-12.3	-14.4	-13.0	-3.8	-18.2	-14.9	15.6	-147.3	-6.6
Middle:										
1979	.047	.626	.710	.800	.123	.274	1.197	.167	-.040	1.324
1989	.026	.648	.706	.828	.091	.196	1.116	.176	-.012	1.279
Change	-.021	.022	-.004	.028	-.032	-.078	-.081	.009	.028	-.045
Percent change	45.3	3.5	-0.6	3.5	-25.7	-28.5	-6.8	5.1	-69.5	-3.4
Fourth:										
1979	.085	1.347	1.528	1.741	.166	.100	2.007	.074	-.158	1.923
1989	.061	1.461	1.598	1.844	.118	.057	2.019	.046	-.149	1.916
Change	-.024	.114	.070	.103	-.048	-.043	.012	-.028	.009	-.007

Percent change	−27.9	8.5	4.6	5.9	−28.9	−43.1	0.6	−37.4	−5.9	−0.4
Highest:										
1979	.301	2.217	2.761	3.334	.239	.064	3.637	.023	−.450	3.210
1989	.216	2.848	3.309	3.938	.185	.013	4.135	.011	−.550	3.596
Change	−.085	.631	.548	.604	−.054	−.051	.498	−.012	−.100	.386
Percent change	−28.2	28.5	19.9	18.1	−22.7	−80.0	13.7	−52.6	22.2	12.0
Total:										
1979	.091	.905	1.076	1.268	.125	.198	1.591	.123	−.133	1.581
1989	.063	1.051	1.188	1.404	.095	.143	1.642	.129	−.140	1.631
Change	−.028	.146	.112	.136	−.030	−.055	.051	.006	−.007	.050
Percent change	−30.7	16.1	10.4	10.7	−23.7	−27.9	3.2	4.8	5.6	3.1

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 61.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, NONELDERLY CHILDLESS UNITS, QUINTILES DEFINED FOR SPECIFIC FAMILY TYPE ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.477	0.390	0.884	1.016	0.154	0.080	1.250	0.023	−0.099	1.174
1989	.474	.368	.860	.995	.143	.063	1.202	.030	−.110	1.122
Change	−.003	−.022	−.024	−.021	−.011	−.017	−.049	.007	−.011	−.052
Percent change	−0.5	−5.6	−2.7	−2.0	−6.9	−21.4	−3.9	31.7	11.0	−4.5
Second:										
1979	1.475	.898	2.460	2.700	.182	.037	2.919	.006	−.392	2.533
1989	1.434	.937	2.494	2.763	.165	.016	2.944	.004	−.419	2.528
Change	−.041	.039	.034	.063	−.017	−.021	.024	−.002	−.027	−.005
Percent change	−2.8	4.3	1.4	2.3	−9.6	−56.5	0.8	−40.0	6.8	−0.2
Middle:										
1979	2.479	1.147	3.826	4.112	.132	.036	4.280	.002	−.719	3.563
1989	2.317	1.394	3.930	4.303	.144	.010	4.457	.001	−.742	3.716
Change	−.162	.247	.103	.191	.012	−.026	.177	−.001	−.023	.153
Percent change	−6.5	21.5	2.7	4.6	9.2	−73.1	4.1	−60.0	3.1	4.3
Fourth:										
1979	3.520	1.371	5.236	5.635	.117	.030	5.782	.001	−1.105	4.678
1989	3.459	1.803	5.657	6.168	.123	.004	6.295	.000	−1.181	5.114
Change	−.061	.432	.421	.533	.006	−.026	.513	−.001	−.076	.436

Percent change	−1.7	31.5	8.0	9.5	4.7	−86.3	8.9	−70.0	6.8	9.3
Highest:										
1979	5.637	1.854	8.032	9.211	.086	.028	9.325	.001	−2.162	7.164
1989	6.207	2.709	9.448	10.799	.116	.002	10.919	.000	−2.400	8.519
Change	.570	.855	1.416	1.588	.030	−.026	1.594	−.001	−.238	1.355
Percent change	10.1	46.1	17.6	17.2	35.1	−92.9	17.1	−80.0	11.0	18.9
Total:										
1979	2.716	1.132	4.086	4.533	.134	.042	4.709	.007	−.895	3.821
1989	2.779	1.442	4.478	5.006	.138	.019	5.163	.007	−.970	4.200
Change	.063	.310	.392	.473	.004	−.023	.454	.000	−.075	.379
Percent change	2.3	27.4	9.6	10.4	3.1	−54.8	9.6	1.4	8.4	9.9

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 62.—AVERAGE ADJUSTED FAMILY INCOME, BY SOURCE OF INCOME, ELDERLY CHILDLESS UNITS, QUINTILES DEFINED FOR SPECIFIC FAMILY TYPE ON THE BASIS OF POST-TAX CASH INCOME PLUS FOOD AND HOUSING ASSISTANCE, WEIGHTED BY PERSONS, 1979 AND 1989

Income quintile and year	Earnings			Total private income	Cash transfer income		Pre-tax cash adjusted income	Means tested noncash transfers	Taxes	Post-tax adjusted income
	Earnings of high adult male	Earnings of high adult female	Total family earnings		Non-means tested cash transfers	Means tested cash transfers				
Lowest:										
1979	0.015	0.015	0.026	0.095	0.657	0.098	0.850	0.029	−0.002	0.877
1989	.015	.022	.036	.129	.768	.068	.964	.039	−.004	.999
Change	−.000	.007	.010	.034	.111	−.030	.114	.010	−.002	.122
Percent change	−2.7	43.3	40.0	35.4	16.8	−30.8	13.4	33.4	100.0	13.9
Second:										
1979	.069	.064	.136	.399	1.021	.089	1.509	.030	−.010	1.529
1989	.078	.078	.164	.503	1.173	.044	1.720	.032	−.019	1.734
Change	.009	.014	.028	.104	.152	−.045	.211	.002	−.009	.205
Percent change	12.6	22.3	20.2	26.1	14.9	−50.8	14.0	6.7	86.0	13.4
Middle:										
1979	.223	.176	.408	1.053	1.157	.045	2.255	.021	−.044	2.232
1989	.236	.200	.451	1.327	1.299	.015	2.641	.003	−.081	2.563
Change	.013	.024	.043	.274	.142	−.030	.386	−.018	−.037	.331
Percent change	5.7	13.4	10.5	26.0	12.3	−66.9	17.1	−87.6	84.1	14.8

Fourth:										
1979	.586	.383	1.014	2.200	1.142	.036	3.378	.012	−.192	3.198
1989	.601	.445	1.119	2.706	1.316	.009	4.031	.001	−.287	3.745
Change	.015	.062	.105	.506	.174	−.027	.653	−.011	−.095	.547
Percent change	2.6	16.1	10.3	23.0	15.2	−75.6	19.3	−92.5	49.5	17.1
Highest:										
1979	1.846	.751	2.784	5.732	1.051	.056	6.839	.001	−1.018	5.822
1989	2.101	.891	3.192	7.314	1.297	.004	8.615	.000	−1.364	7.251
Change	.255	.140	.408	1.582	.246	−.052	1.776	−.001	−.346	1.429
Percent change	13.8	18.7	14.7	27.6	23.4	−92.5	26.0	−60.0	34.0	24.5
Total:										
1979	.548	.278	.873	1.895	1.006	.065	2.966	.019	−.254	2.731
1989	.606	.327	.992	2.396	1.171	.028	3.595	.015	−.351	3.258
Change	.058	.049	.119	.501	.164	−.037	.629	−.004	−.097	0.527
Percent change	10.6	17.7	13.7	26.4	16.4	−57.1	21.2	−21.6	−38.2	19.3

Note.—Adjusted family income is income as a fraction of the poverty threshold.

Source: Congressional Budget Office tabulations of data from the March Current Population Survey, 1980 and 1990.

TABLE 63.—EARNINGS AND TRANSFERS AS PERCENT OF INCOME, BY INCOME QUINTILE (COMPUTED FOR ALL FAMILIES) BY AGE, SEX, AND INCOME MEASURE, 1989

Income quintile and year	Earnings	Cash transfers	Other income	Pretax income
Lowest:				
Mean family cash income	37.1	51.0	11.9	100.0
Per capita income	70.1	25.1	4.8	100.0
Pretax AFI	53.7	38.1	8.3	100.0
Pretax AFI (1979)	51.6	41.0	7.3	100.0
Second:				
Mean family cash income	61.7	22.9	15.5	100.0
Per capita income	77.4	16.2	6.5	100.0
Pretax AFI	73.1	16.8	10.1	100.0
Pretax AFI (1979)	75.1	16.0	8.8	100.0
Middle:				
Mean family cash income	76.4	10.2	13.4	100.0
Per capita income	81.0	10.6	8.4	100.0
Pretax AFI	81.7	8.3	10.0	100.0
Pretax AFI (1979)	84.1	7.7	8.1	100.0
Fourth:				
Mean family cash income	84.6	4.8	10.6	100.0
Per capita income	81.6	7.4	11.0	100.0
Pretax AFI	85.4	4.8	9.8	100.0
Pretax AFI (1979)	88.0	4.2	7.7	100.0
Highest:				
Mean family cash income	84.8	2.1	13.1	100.0
Per capita income	79.4	3.6	17.0	100.0
Pretax AFI	83.5	2.3	14.2	100.0
Pretax AFI (1979)	85.5	2.2	12.3	100.0
Total:				
Mean family cash income	79.6	7.7	12.7	100.0
Per capita income	79.6	7.7	12.7	100.0
Pretax AFI	81.3	7.0	11.7	100.0
Pretax AFI (1979)	82.9	7.2	9.8	100.0

Source: Congressional Budget Office.

TABLE 64.—PERCENT DISTRIBUTION OF PERSONS ACROSS INCOME, QUINTILES (COMPUTED FOR ALL FAMILIES) BY AGE, SEX, AND INCOME MEASURE, 1979, 1989

Income quintile and year	Under age 18		Ages 18 through 64		Age 65 and over		All ages	
	1979	1989	1979	1989	1979	1989	1979	1989
Lowest:								
Mean family cash income	12.0	14.5	10.3	11.4	32.5	26.7	13.2	14.1
Per capita income	31.2	34.0	15.0	15.8	18.7	11.1	20.0	20.0
Pretax AFI	25.8	27.7	15.0	15.5	32.8	26.2	20.0	20.0
Second:								
Mean family cash income	15.4	15.8	14.7	14.9	29.5	28.2	16.5	16.7
Per capita income	25.0	25.0	16.4	17.3	27.4	23.3	20.0	20.0
Pretax AFI	23.5	22.5	17.2	17.5	26.9	27.1	20.0	20.0
Middle:								
Mean family cash income	20.5	19.5	19.9	19.4	17.9	20.1	19.8	19.5
Per capita income	21.7	20.9	19.2	19.3	20.2	21.8	20.0	20.0
Pretax AFI	22.2	21.4	19.7	19.7	16.2	18.4	20.0	20.0
Fourth:								
Mean family cash income	26.3	24.7	24.8	24.5	10.5	13.1	23.7	23.2
Per capita income	15.8	13.8	22.5	22.1	17.0	22.3	20.0	20.0
Pretax AFI	18.0	17.2	22.3	22.2	12.0	14.6	20.0	20.0
Highest:								
Mean family cash income	25.8	25.4	30.4	29.8	9.5	11.8	26.8	26.5

TABLE 64.—PERCENT DISTRIBUTION OF PERSONS ACROSS INCOME, QUINTILES (COMPUTED FOR ALL FAMILIES) BY AGE, SEX, AND INCOME MEASURE, 1979, 1989—Continued

Income quintile and year	Under age 18		Ages 18 through 64		Age 65 and over		All ages	
	1979	1989	1979	1989	1979	1989	1979	1989
Per capita income	6.3	6.3	26.9	25.5	16.7	21.6	20.0	20.0
Pretax AFI	10.5	11.1	25.8	25.0	12.1	13.6	20.0	20.0
Total:								
Mean family cash income	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Per capita income	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pretax AFI	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Congressional Budget Office.

TRENDS IN FAMILY INCOME AND INCOME INEQUALITY: 1950–1980 [15]

This section examines in identical fashion to the previous section changes in income distribution for the entire population from 1950 to 1980. These data are from the 1950, 1960, 1970 and 1980 census files. Income is total pretax cash income from all sources. Census, as compared to CPS data, has more underreporting of income. Nevertheless, the surveys were done in a similar fashion and the data should give an accurate portrayal of the changes in income distribution over time.

Tables 65 and 66 are consistent with part B of tables 26 and 28. In particular, the term "adjusted family income" refers to family income divided by the poverty threshold. "Weighted by individuals" means that each person, rather than each family, carries an equal weight. Thus, exactly 20 percent of the population is in each quintile. The first entry in table 65 should be read: the mean family income of the 20 percent of persons with the lowest incomes in 1950 was 23 percent of the poverty threshold. The first entry in table 66 should be read: the share of adjusted family income of the poorest 20 percent of persons was 3.1 percent in 1950.

Table 65 shows that the greatest growth in income was between 1950 and 1960, when average adjusted family income grew 53.5 percent. Income growth in the 1950's and 1960's was equalizing, as the greatest percentage growth in income was in the lower quintiles. In contrast, in the 1970's, the greatest growth was experienced by persons with adjusted family income in the upper three quintiles. This trend can also be seen from table 64, which shows shares of adjusted family income. While the share of income of the lowest quintile grew substantially in the 1950's, this trend slowed in the 1960's and by the 1970's the share of income received by the lowest quintile began to shrink.

---

[15] Special tabulations from the 1950, 1960, 1970, and 1980 Census Public Use tapes by Sheldon Danziger, Institute of Public Policy Studies, University of Michigan.

TABLE 65.—FAMILY INCOME BY INCOME QUINTILE AND CHANGE OVER TIME 1950, 1960, 1970, 1980, ALL FAMILIES

[Adjusted family income, weighted by persons]

Income quintile	1950	1960	1970	1980	Percent change			
					50–60	60–70	70–80	50–80
Lowest	0.23	0.49	0.71	0.76	117.7	43.5	7.9	237.2
Second	0.77	1.25	1.71	1.86	62.6	36.6	9.3	142.7
Middle	1.23	1.86	2.52	2.84	51.0	35.1	12.8	130.1
Fourth	1.79	2.64	3.53	4.01	47.3	33.7	13.8	124.2
Highest	3.32	5.03	6.60	7.28	51.4	31.2	10.3	119.0
Average	1.47	2.25	3.01	3.35	53.5	33.5	11.3	128.3

TABLE 66.—PERCENTAGE SHARES OF FAMILY INCOME BY INCOME QUINTILE AND CHANGE OVER TIME 1950, 1960, 1970, 1980, ALL FAMILIES

[Adjusted family income, weighted by persons]

Income quintile	1950	1960	1970	1980	Percent change			
					50–60	60–70	70–80	50–80
Lowest	3.1	4.4	4.7	4.5	41.7	7.5	−3.0	47.7
Second	10.5	11.1	11.3	11.1	5.9	2.3	−1.8	6.3
Middle	16.8	16.5	16.7	16.9	−1.7	1.2	1.3	0.8
Fourth	24.4	23.4	23.4	24.0	−4.1	0.1	2.3	−1.8
Highest	45.3	44.6	43.8	43.4	−1.4	−1.8	−0.9	−4.0
Total	100.0	100.0	100.0	100.0				

APPENDIX J.—THE DISTRIBUTION OF INCOME AND TAX BURDENS BY HOUSEHOLD

HYPOTHETICAL TAX CALCULATIONS FOR SELECTED FAMILIES

The following table presents taxable income levels, values of the personal exemptions, standard deductions, and additional standard deductions for the elderly and the blind for tax years 1989–1992.

TABLE 1.—PERSONAL EXEMPTIONS, STANDARD DEDUCTIONS, AND TAXABLE INCOME LEVELS

	1989	1990	1991	1992 projected
Personal exemptions	$2,000	$2,050	$2,150	$2,300
Standard deductions:				
Joint	5,200	5,450	5,700	6,000
Single	3,100	3,250	3,400	3,600
Head of household	4,550	4,750	5,000	5,300
Additional standard deductions for elderly/blind:				
Joint (each individual)	600	650	650	700
Single/head of household	750	800	850	900
Taxable Income Levels				
Joint returns:				
15 percent rate ends at	30,950	32,450	34,000	35,800
28 percent rate ends at	74,850	78,400	82,150	86,550
Single returns:				
15 percent rate ends at	18,550	19,450	20,350	21,450
28 percent rate ends at	44,900	47,050	49,300	51,950
Heads of households:				
15 percent rate ends at	24,850	26,050	27,300	28,750
28 percent rate ends at	64,200	67,200	70,450	74,200

Source: Congressional Budget Office.

Table 2 presents examples of tax liabilities for hypothetical taxpayers. The table presents 1991 Federal income and payroll tax burdens. The worker is assumed to bear both the employer and employee shares of FICA tax (7.65 percent for each.) Taxpayers claim the earned income tax credit, if eligible, and they claim the standard deduction. They do not itemize. Income sources are listed for each example.

TABLE 2.—EXAMPLES OF FEDERAL INCOME AND PAYROLL TAX LIABILITIES OF HYPOTHETICAL TAXPAYERS, 1991

Income	Income tax liability	FICA tax liability	Total tax liability	Overall effective tax rate [1] (percent)	Overall marginal tax rate (percent)
Joint filer—3 exemptions: [2]					
$10,000	−$1,192	$1,530	$338	3.1	14.2
$30,000	2,678	4,590	7,268	22.5	29.2
$50,000	6,178	7,650	13,828	25.7	42.2
$100,000	20,349	8,170	28,519	27.4	31.0
Head of household—2 personal exemptions: [2]					
$10,000	−1,087	1,530	443	4.2	29.2
$30,000	3,105	4,590	7,695	23.8	29.2
$50,000	7,847	7,650	15,497	28.8	43.0
$100,000	22,455	8,170	30,625	29.4	31.0
Elderly couple filing joint return:					
$10,000 [3]	0	0	0	0.0	[6] 0.0
$30,000 [4]	1,005	0	1,005	3.4	[7] 15.0
$50,000 [5]	4,905	1,530	6,435	12.7	29.2
Elderly single filer:					
$10,000 [8]	0	0	0	0.0	[6] 0.0
$30,000 [9]	2,509	0	2,509	8.4	[11] 22.5
$50,000 [10]	8,513	3,060	11,573	22.5	42.2

[1] The effective tax rate is total tax liability divided by income plus the employer share of FICA. The marginal rate computations also count the employer share of FICA tax as income to the employee.

[2] Assumes one child, one earner and all income is wage income.

[3] All income is Social Security.

[4] $12,000 is Social Security, $12,000 is a taxable pension and $6,000 is taxable interest.

[5] Same as above plus additional $10,000 of taxable interest and $10,000 of wages.

[6] If the marginal dollar of income is assumed to consist of wage income, the marginal tax rate would be 14.2 higher. This represents the FICA tax liability on this income.

[7] If the marginal dollar of income is assumed to consist of wage income, the marginal tax rate would be 29.2 percent, representing both the income tax liability and the FICA tax liability on this income.

[8] $7,500 is Social Security, $2,500 is taxable pension.

[9] $7,500 is Social Security, $7,500 is taxable pension, $15,000 is taxable interest.

[10] Same as above plus $20,000 of wages.

[11] If the marginal dollar of income is assumed to consist of wage income, the marginal tax rate would be 36.7 percent, representing both the income tax liability (22.5 percent marginal rate reflects the inclusion of 50 cents of Social Security benefits as taxable for each additional dollar of AGI) and the FICA tax liability on this income.

Source: Joint Committee on Taxation.

TAX TREATMENT OF THE ELDERLY

Present law contains several provisions that reduce, or in some cases eliminate, the burden of Federal income tax on senior citizens. These provisions are: the exemption from income taxation of some or all of an individual's Social Security benefits; a tax credit for certain taxpayers who do not receive substantial Social Security income; and an additional standard deduction for taxpayers age 65 and older.

Under present law, every person who is blind or elderly is entitled to an addition to the person's standard deduction. For 1991, these additional amounts are $650 for each married individual who is blind or elderly and $850 for each unmarried individual who is blind or elderly. A person who is both blind and elderly is entitled to an addition to the individual's standard deduction of $1,300 if married or $1,700 if unmarried. These amounts are adjusted for increases in the Consumer Price Index.

Social Security benefits are fully tax-exempt for taxpayers whose adjusted gross income plus tax-exempt bond interest plus half of Social Security benefits do not exceed a threshold of $25,000 for individuals and $32,000 for couples. If this modified adjusted gross income exceeds the threshold, then the amount of Social Security benefits subject to taxation is an amount equal to the lesser of: (1) half of the Social Security benefits, or (2) half of the amount by which modified adjusted gross income exceeds the threshold.

A nonrefundable tax credit is available for certain individuals who are age 65 or over, or who are under 65 but have retired on permanent and total disability. The credit is intended to remove inequities between individuals who receive retirement or disability income which is not tax-exempt and individuals who receive Social Security, which is mostly tax-exempt. Most of those who are able to take advantage of the credit have incomes below $30,000 per year.

The additional standard deduction, the tax treatment of Social Security benefits, and the special tax credit are described in greater detail in section 12.

As a result of these favorable tax provisions, the "tax threshold" (the level of income, excluding Social Security, at which tax liability is incurred) for seniors is well above the poverty level. For example, in 1991, a single elderly individual with $5,000 in Social Security benefits can have up to $6,400 in other income without incurring tax liability (or total income of $11,400). An elderly married couple filing jointly with $5,000 in Social Security benefits has a tax threshold of $12,533 (or total income of $17,533). Table 3 displays similar information for other years and for varying amounts of Social Security benefits.

The combination of these tax provisions ensures that an estimated 40.0 percent of elderly individuals will have no tax liability for 1991 (see table 4). (The methodology used to update this table has been significantly changed since last year's edition of the Green Book.) The discussion later in this appendix, particularly tables 20 and 30, compare effective tax rates for the elderly and nonelderly.

TABLE 3.—INCOME TAX THRESHOLDS FOR ELDERLY INDIVIDUALS,[1] 1988–92

Year and filing status	Amount of Social Security income			
	Zero	$2,500	$5,000	$7,500
1988:				
Single	9,633	7,967	5,700	5,700
Joint	15,067	13,400	11,733	10,100
1989:				
Single	9,733	8,067	5,850	5,850
Joint	15,267	13,600	11,933	10,400
1990:				
Single	9,900	8,233	6,100	6,100
Joint	15,567	13,900	12,233	10,850
1991:				
Single	10,100	8,433	6,400	6,400
Joint	15,867	14,200	12,533	11,300
1992: [2]				
Single	10,367	8,700	6,800	6,800
Joint	16,333	14,667	13,000	12,000

[1] Tax threshold is amount of adjusted gross income (excluding Social Security) at which tax liability begins. Table assumes taxpayers are 65 or older, are not blind, and receive no tax-exempt disabilty benefit, annuity, or pension income other than Social Security income.

[2] Estimated.

Source: Congressional Budget Office.

TABLE 4.—DISTRIBUTION OF ELDERLY BY INCOME CLASS, CALENDAR YEAR 1991

Income class [1] (thousands)	Number of elderly individuals (thousands)	Percentage of distribution
Taxable returns:		
0 to $10	145	0.5
$10 to $20	1,953	6.9
$20 to $30	4,266	15.0
$30 to $40	3,926	13.8
$40 to $50	2,523	8.9
$50 to $75	2,373	8.4
$75 to $100	823	2.9
$100 to $200	674	2.4
$200 and over	331	1.2
Nontaxable returns	11,341	40.0
Total	28,355	100.0

[1] The income concept used to place tax returns into income classes is adjusted gross income plus (1) tax-exempt interest, (2) employer contributions for health plans and life insurance, (3) inside build-up on life insurance, (4) workers' compensation, (5) social security benefits, (6) contributions to individual retirement accounts, (7) the minimum tax preferences, and (8) net losses, in excess of minimum tax preferences, from passive business activities.

Note.—The methodology used to update this table has significantly changed since last year's edition.

Source: Joint Committee on Taxation.

Table 5 shows marginal tax rates (the additional Federal income tax and the employee share of the payroll tax on one dollar of additional earnings) for people age 65 and older based on simulations. About half of elderly persons, 51.1 percent, have marginal tax rates of 5.0 to 9.9 percent, and another quarter are in the 20.0 to 24.9 percent bracket.

When analyzing the marginal tax rates of the elderly, some people include the benefit reductions under the retirement test as a "tax." However, the retirement test is not a tax but is instead a test of eligibility for retirement benefits. If an individual under age 70 is working, he or she is not considered retired and thus is not eligible for Social Security retirement benefits. Specifically, for individuals age 65–69 who have earnings in excess of $9,360 in 1990, Social Security benefits are reduced by $1 for every $3 in earnings above this amount. However, these benefits are not permanently foregone. They are partially repaid in the form of increases in future benefit amounts through the mechanism of the delayed retirement credit (DRC). DRCs are given for every month after age 65 in which benefits are not paid, either because the individual has not filed for benefits or because the benefits were reduced under the retirement test. Prior to 1990, DRCs were equal to 3 percent per year. This compensated for about 40 percent of the benefit reduction. However, in 1990 the value of DRCs began to increase and will ultimately reach 8 percent per year for workers attaining age 65 after 2007. This is an actuarially fair DRC that fully compensates a worker who does not receive benefits for some or any months between ages 65 and 70. A more detailed explanation of the retirement test and the delayed retirement credit can be found in section 1.

In 1992 it is estimated that there are about 400,000 persons whose benefits are affected by the retirement test, but who receive some benefits. If we consider the effective tax rate in the earnings test to be 20 percent (60 percent of 33.3), approximately 218,000 elderly individuals (less than 1 percent of all elderly) have a marginal tax rate above 50 percent.

Table 6 shows the marginal tax rates for single earners, married earners, and earners with children. For a typical single wage earner with an income between $20,000 and $30,000 per year, that person has a marginal tax rate of 20.0 to 24.9 percent.

TABLE 5.—DISTRIBUTION OF PEOPLE AGE 65 AND OVER BY MARGINAL TAX RATES ON WAGES,[1] 1992

[In thousands]

Marginal tax rate (percent)	Ages 65–69		Age 70 and over	Total age 65 and over	Percent of total age 65 and over
	Benefits not reduced for additional earnings[2]	Benefits reduced for additional earnings			
Less than 0	70	0	50	120	0.4
0 to 4.9	1	0	3	4	0
5.0 to 9.9	4,325	6	11,427	15,758	51.1
10.0 to 14.9	1	0	0	1	0
15.0 to 19.9	6	0	2	8	0
20.0 to 24.9	3,076	178	4,695	7,949	25.8
25.0 to 29.9	44	1	10	55	.2
30.0 to 34.9	1,280	88	1,919	3,287	10.7
35.0 to 39.9	1,329	125	1,834	3,288	10.7
40.0 to 44.9	67	3	83	153	.5
45.0 to 49.9	59	2	124	186	.6
Total	10,260	402	20,147	30,809	100.0

---

[1] Marginal tax rates are the combined tax rates on an additional dollar of earnings of the Federal individual income tax and the employee share of the Social Security payroll tax (FICA).

[2] In 1992, the earnings limit is projected to be $10,200. This column includes persons with earnings below $10,200 and persons whose benefits have been reduced to zero by the earnings test.

Source: Congressional Budget Office simulations.

TABLE 6.—DISTRIBUTION OF EARNERS BY INCOME AND MARGINAL TAX RATES ON WAGES [1] FOR EARNERS, 1992

[Income in thousands]

Marginal tax rate	<10	10–20	20–30	30–40	40–50	50–75	75–100	100–200	200+	All income
	All earners ages 21–64 without Social Security benefits									
Less than 0	3,041	279	39	12	0	0	0	1	0	3,371
0 to 4.9	4	29	2	0	0	0	0	0	0	34
5.0 to 9.9	7,192	1,415	126	14	0	2	9	0	0	8,759
10.0 to 14.9	0	0	0	0	0	5	0	0	0	5
15.0 to 19.9	0	43	5	8	23	185	0	0	0	263
20.0 to 24.9	4,851	13,668	16,734	12,198	10,434	4,287	18	0	0	62,191
25.0 to 29.9	0	447	55	1	36	1,896	1,809	347	0	4,591
30.0 to 34.9	0	24	4	100	150	226	261	1,918	1,005	3,688
35.0 to 39.9	0	3,326	2,169	3,383	2,343	13,802	4,723	1,754	268	31,770
40.0 to 44.9	0	841	646	13	0	3	3	200	189	1,895
45.0 to 49.9	0	0	0	0	0	1	0	0	0	1
Total	15,087	20,070	19,780	15,731	12,986	20,408	6,823	4,219	1,462	116,568
	Single earners									
Less than 0	1,106	98	0	0	0	0	0	0	0	2,204
0 to 4.9	0	3	0	0	0	0	0	0	0	3
5.0 to 9.9	5,568	351	9	5	0	0	0	0	0	5,993
10.0 to 14.9	0	0	0	0	0	0	0	0	0	0
15.0 to 19.9	0	15	0	0	0	0	0	0	0	15
20.0 to 24.9	4,851	10,687	7,286	975	133	10	1	0	0	23,944
25.0 to 29.9	0	69	0	1	27	545	29	4	0	675
30.0 to 34.9	0	0	0	0	0	205	230	250	150	834
35.0 to 39.9	0	1,592	1,163	3,348	1,784	1,020	68	29	3	9,007

TABLE 6.—DISTRIBUTION OF EARNERS BY INCOME AND MARGINAL TAX RATES ON WAGES [1] FOR EARNERS, 1992—Continued

[Income in thousands]

Marginal tax rate	<10	10–20	20–30	30–40	40–50	50–75	75–100	100–200	200+	All income
40.0 to 44.9	0	367	100	0	0	0	0	21	2	490
45.0 to 49.9	0	0	0	0	0	0	0	0	0	0
Total	12,525	13,183	8,559	4,329	1,945	1,780	328	304	154	43,106
	Married earners									
Less than 0	934	181	39	12	0	0	0	1	0	1,167
0 to 4.9	3	26	2	0	0	0	0	0	0	31
5.0 to 9.9	1,624	1,064	117	10	0	2	9	0	0	2,826
10.0 to 14.9	0	0	0	0	0	5	0	0	0	5
15.0 to 19.9	0	28	5	8	23	185	0	0	0	248
20.0 to 24.9	0	2,980	9,447	11,223	10,301	4,277	17	0	0	38,247
25.0 to 29.9	0	378	55	0	9	1,351	1,780	343	0	3,916
30.0 to 34.9	0	24	4	100	150	21	31	1,668	855	2,853
35.0 to 39.9	0	1,734	1,006	35	559	12,783	4,655	1,725	266	22,763
40.0 to 44.9	0	474	545	13	0	3	3	179	188	1,405
45.0 to 49.9	0	0	0	0	0	1	0	0	0	1
Total	2,562	6,888	11,222	11,402	11,042	18,628	6,495	3,915	1,308	73,462
	Earners with children									
Less than 0	2,745	261	35	8	0	0	0	1	0	3,050
0 to 4.9	4	25	0	0	0	0	0	0	0	29
5.0 to 9.9	1,213	938	66	5	0	2	0	0	0	2,224
10.0 to 14.9	0	0	0	0	0	5	0	0	0	5
15.0 to 19.9	0	28	2	5	15	180	0	0	0	231

20.0 to 24.9	20	1,389	6,487	7,318	6,473	3,466	8	0	0	25,161
25.0 to 29.9	0	444	51	0	12	958	1,067	176	0	2,707
30.0 to 34.9	0	0	0	15	14	11	15	814	433	1,302
35.0 to 39.9	0	2,757	1,168	41	167	6,267	2,294	734	149	13,578
40.0 to 44.9	0	793	613	13	0	3	3	88	100	1,613
45.0 to 49.9	0	0	0	0	0	0	0	0	0	0
Total	3,981	6,636	8,422	7,407	6,681	10,892	3,385	1,813	681	49,899

---

[1] Marginal tax rates are the combined tax rates on an additional dollar of earnings of the Federal individual income tax and the employee share of the Social Security payroll tax (FICA).

Source: Congressional Budget Office simulations.

FEDERAL TAX TREATMENT OF FAMILIES IN POVERTY

In the past two decades, Congress has attempted to ensure that families in poverty do not pay Federal income taxes. These legislative efforts reflect the policy that a family should not be liable for income tax until income exceeds the poverty threshold (as measured by the standards set by the U.S. Bureau of the Census).

The trend from the 1970s until 1986, was that inflation gradually increased the tax burdens of the poor and lowered the real income level at which a poor family became liable for income tax. Legislation enacted by Congress reversed or slowed this trend, but in the absence of indexing, inflation gradually offset these legislative efforts. This trend can be measured in two ways. One measure is the degree to which the income at which a poor family begins to pay income taxes (termed the tax threshold, or alternatively, the tax entry point) exceeds or falls below that family's poverty threshold. A second measure is the actual amount of tax liability incurred by a family with income at the poverty line.

Table 7 shows the income tax threshold, the poverty level, and the tax threshold as a percent of the poverty level for a married couple with two children in selected years since 1959. These figures demonstrate that before 1974 a family of four was generally liable for Federal income tax, even though the family's income was significantly below the poverty line. In 1975, following the enactment of the earned income credit, a family of four incurred no tax liability until its income exceeded the poverty threshold by 22 percent. Over the next decade this margin eroded; by 1984, a poor family of four incurred income tax liability when its income was 17 percent *below* the poverty line. In 1991, a married couple with two children has an income tax threshold of $13,820 without taking into account the EITC. When the EITC is included, the income tax threshold increases to approximately $17,437.

Table 8 shows the income tax burden and payroll tax burden of households with incomes at the poverty line given different family sizes. This table shows that a family of four in 1978 had an income tax refund (through the earned tax credit) of $134; refund offset 33 percent of the family's payroll tax burden of $403. By 1986, a family in the same situation incurred a positive tax liability of $363. Combined income and payroll taxes represented 4 percent of this family income for a family with income equal to the poverty level in 1978; by 1986, combined income and payroll taxes consumed 10.4 percent of family income.

The Tax Reform Act of 1986 significantly increased the income tax entry point for poor families with children. Because the system as enacted is indexed to inflation, future increases in the Consumer Price Index will not erode these tax benefits.

TABLE 7.—RELATIONSHIP BETWEEN INCOME TAX THRESHOLD AND POVERTY LEVEL FOR A FAMILY OF FOUR, 1959–1994

Year	Income tax threshold	Poverty level	Tax threshold as a percent of poverty level
1959	$2,667	$2,973	89.7
1960	2,667	3,022	88.3
1965	3,000	3,223	93.1
1966	3,000	3,317	90.4
1968	3,000	3,553	84.4
1969	3,000	3,743	80.2
1970	3,600	3,968	90.7
1971	3,750	4,137	90.6
1972	4,300	4,275	100.6
1973	4,300	4,540	94.7
1974	4,300	5,038	85.4
1975	6,692	5,500	121.7
1976	6,892	5,815	118.5
1977	7,520	6,191	121.7
1978	7,533	6,662	113.1
1979	8,626	7,412	116.4
1980	8,626	8,414	102.5
1981	8,634	9,287	93.0
1982	8,727	9,862	88.5
1983	8,783	10,178	86.3
1984	8,783	10,610	82.8
1986	9,575	11,203	85.5
1987	13,288	11,611	114.4
1988	15,110	12,092	125.0
1989	15,656	12,675	123.5
1990	16,296	13,186	123.6
1991 [1]	17,437	13,820	126.2
1992 [1]	18,553	14,505	127.9
1993 [1]	19,252	15,026	128.1
1994 [1]	20,479	15,568	131.5

[1] Estimated.

[2] Effective payroll tax calculated as 6.7 percent for 1984 because in this year employees were allowed a payroll tax credit equal to 0.3 percent of taxable wages.

Note: Tax thresholds assume full use of the earned income tax credit. They are based on the schedule for a married nonelderly couple filing jointly. The poverty level figures are for all families, not just those with heads under age 65.

Assumes no children are under 1 and the family does not claim health insurance supplement to EITC.

Source: Congressional Budget Office.

TABLE 8.—TAX THRESHOLDS, POVERTY LEVELS, AND FEDERAL TAX AMOUNTS FOR DIFFERENT FAMILY SIZES WITH EARNINGS EQUAL TO THE POVERTY LEVEL, 1978–1994 [1]

	Family size—					
	1	2	3	4	5	6
Poverty levels:						
1978	$3,311	$4,249	$5,201	$6,662	$7,880	$8,891
1982	4,900	6,280	7,690	9,862	11,680	13,210
1983	5,061	6,483	7,938	10,178	12,049	13,630
1984	5,277	6,759	8,276	10,610	12,562	14,211
1986	5,572	7,138	8,737	11,203	13,259	14,986
1987	5,778	7,397	9,056	11,611	13,737	15,509
1988	6,024	7,704	9,435	12,092	14,305	16,149
1989	6,311	8,076	9,885	12,675	14,990	16,921
1990	6,565	8,402	10,284	13,186	15,594	17,603
1991 [3]	6,881	8,805	10,778	13,820	16,344	18,449
1992 [3]	7,222	9,242	11,312	14,505	17,154	19,364
1993 [3]	7,482	9,574	11,719	15,026	17,770	20,060
1994 [3]	7,751	9,919	12,141	15,568	18,411	20,783
Income tax threshold:[1]						
1978	3,200	5,200	6,930	7,520	8,183	9,167
1982	3,300	5,400	8,237	8,727	9,216	9,706
1983–84	3,300	5,400	8,315	8,783	9,251	9,719
1986	3,560	5,830	9,063	9,575	10,086	10,598
1987	4,440	7,560	12,292	13,288	14,283	15,278
1988	4,950	8,900	13,940	15,110	16,280	17,450
1989	5,100	9,200	14,456	15,656	16,856	18,056
1990	5,300	9,550	15,066	16,296	17,526	18,756
1991	5,550	10,000	16,179	17,437	18,616	19,794
1992 [3]	5,900	10,600	17,222	18,553	19,779	21,005
1993 [3]	6,050	10,900	17,904	19,252	20,471	21,689
1994 [3]	6,300	11,350	19,148	20,479	21,597	22,715
Income tax at poverty level:[1]						
1978	16	0	−280	−134	−12	0
1982	202	106	−134	285	417	491
1983	209	118	−89	319	432	509
1984	226	149	−9	364	478	569
1986	230	144	−76	363	480	564
1987	147	0	−635	−352	−113	54
1988	161	0	−874	−648	−427	−243
1989	182	0	−910	−666	−435	−242
1990	190	0	−953	−708	−467	−266
1991 [3]	200	0	−1,192	−918	−606	−345
1992 [3]	198	0	−1,324	−1,035	−687	−396
1993 [3]	215	0	−1,441	−1,137	−754	−435
1994 [3]	218	0	−1,858	−1,511	−1,004	−580
Payroll tax at poverty level:						
1978	200	257	315	403	477	538
1982	328	421	515	661	783	885

TABLE 8.—TAX THRESHOLDS, POVERTY LEVELS, AND FEDERAL TAX AMOUNTS FOR DIFFERENT FAMILY SIZES WITH EARNINGS EQUAL TO THE POVERTY LEVEL, 1978–1994 [1]—Continued

	Family size—					
	1	2	3	4	5	6
1983	339	435	532	682	808	913
1984 [2]	354	453	555	711	842	953
1986	398	510	625	801	948	1,071
1987	413	529	648	830	983	1,111
1988	452	579	709	908	1,074	1,213
1989	474	607	742	952	1,126	1,271
1990	502	643	787	1,009	1,193	1,347
1991 [3]	526	674	825	1,057	1,250	1,411
1992 [3]	552	707	865	1,110	1,312	1,481
1993 [3]	572	732	897	1,149	1,359	1,535
1994 [3]	593	759	929	1,191	1,408	1,590
Combined income and payroll tax at poverty level:						
1978	216	257	35	269	465	538
1982	530	527	381	946	1,200	1,376
1983	546	554	443	1,001	1,240	1,422
1984	580	602	546	1,075	1,320	1,521
1986	628	654	549	1,164	1,428	1,635
1987	560	529	12	479	869	1,164
1988	614	579	−165	256	647	970
1989	656	607	−168	285	691	1,029
1990	692	643	−167	301	726	1,081
1991 [3]	726	674	−368	140	645	1,066
1992 [3]	751	707	−458	75	626	1,085
1993 [3]	787	732	−545	13	605	1,099
1994 [3]	811	759	−930	−320	405	1,010
Combined tax as percent of income at poverty level:						
1978	6.5	6.1	0.7	4.0	5.9	6.1
1982	10.8	8.4	5.0	9.6	10.3	10.4
1983	10.8	8.6	5.6	9.8	10.3	10.4
1984	11.0	8.9	6.5	10.1	10.5	10.7
1986	11.3	9.2	6.3	10.4	10.8	10.9
1987	9.7	7.2	.1	4.1	6.3	7.5
1988	10.2	7.5	−1.7	2.1	4.5	6.0
1989	10.4	7.5	−1.7	2.3	4.6	6.1
1990	10.5	7.6	−1.6	2.3	4.7	6.1
1991 [3]	10.6	7.6	−3.4	1.0	3.9	5.8
1992 [3]	10.4	7.6	−4.1	0.5	3.6	5.6
1993 [3]	10.5	7.6	−4.6	0.1	3.4	5.5
1994 [3]	10.5	7.6	−7.7	−2.1	2.2	4.9

[1] The table reflects assumptions that all family income consists of wages or salaries, that families of two or more include a married couple (rather than an unmarried head of household with one or more dependents), that all family members are under age 65, and that families of three or more persons are eligible for the earned income credit. For families of three or more, the effect of the earned income credit is included. Negative figures in the table reflect refundability of earned income credit. The poverty level figures are for all families, not just those with heads under age 65.

[2] Effective payroll tax calculated as 6.7 percent for 1984 because in this year employees were allowed a payroll tax credit equal to 0.3 percent of taxable wages.

[3] Estimated.

Source: Congressional Budget Office.

STATE INCOME AND SALES TAXES

OVERVIEW OF TABLES

The estimated burden of *State sales taxes* for two groups of persons at the poverty level—poor elderly individuals and poor married-couple families of four—increased or stayed the same from 1980 to 1988 in almost all States[1]. Changes in the estimated burden of *State income taxes* in the same period were more complex: the burden was about equally likely to increase or decrease for poor and near-poor (150 percent of the official poverty level) families of four, but poor and near-poor elderly individuals paid no tax in both years in almost all States. Thus, State sales taxes constituted a greater burden than State income taxes for the poor family of four and for the poor elderly.

These findings seem to be explained primarily by three facts: (1) sales taxes apply to persons at all income levels and at the same rate; (2) only some States indexed their income tax rate schedules for inflation over this period; and (3) State income tax structures parallel the Federal structure of providing favorable treatment of Social Security benefits, which protects almost all the poor and near-poor elderly from paying any State income tax.

These findings are derived from tax simulations by GAO which assume equivalent distributions of income and expenditures in both years and across States. Thus, the tax estimates reported do not represent the actual taxes paid by families, but are intended to illustrate the effects of changes in State tax structures, holding other changes constant.

State income taxes

Forty-one States (including the District of Columbia) taxed the income of their residents in both 1980 and 1988, while another (Alaska) had eliminated its State income tax by 1988. Three additional States limited taxable income to interest and dividends at levels not affecting the present analysis. The number of States that would have taxed poor or near-poor families remained relatively stable from 1980 to 1988. Moreover, the tax that families would have paid, if liable, was generally fairly low.

Elderly individuals with cash income at the poverty level would typically have had no State income tax liability in 1980 or 1988, because their primary income source—Social Security benefits—was exempt from taxes.[2] Few States (one in 1980 and four in 1988) would have taxed near-poor elderly individuals. Moreover, the highest estimated tax liability in each year was only half a percent of income (in Pennsylvania). (Data not shown in the accompanying tables.)

---

[1] State excise taxes on gasoline, tobacco, and alcohol were excluded from these analyses.

Low-income married-couple families of four, however, were more likely to be taxed than elderly individuals. In 1988, 22 of the 41 taxing States would have taxed married-couple families at the poverty level, down from 33 States in 1980 (see table 9). However, a considerable number of States in both years would have taxed this group at very low levels. In 1980, 15 of the 42 taxing States would have taxed this group at below half a percent of their income (with 9 having no tax); in 1988, for 25 States the tax would have been below half a percent (with 19 having no tax). In 1980, the highest estimated tax liability was 2.2 percent (in Minnesota), while in 1988, the highest was 2.7 percent (in Kentucky).

The estimated tax liability of poverty-level married-couple families changed in most States (32 of the taxing States) between 1980 and 1988. Among these changes, there were slightly more decreases in tax liability (19) than increases (13). However, most of these changes (25 of 32) were modest (representing less than 1.0 percent of family income).

In contrast, almost all taxing States would have taxed near-poor married-couple families (at 150 percent of poverty) (see table 10). Estimated tax liability for the near-poor families ranged from 0.1 to 4.6 percent of income in 1980, but only one in 1988, would have taxed families in this group at less than half a percent.

Estimated tax liabilities varied widely across the several States for the near-poor married couples. All but 1 taxing State showed a change in tax liability; a majority of these States (24) would have increased this group's taxes as a proportion of income. Some 7 of the 41 States showed changes of 1.0 percent of income or more; of these, 4 had decreases and 3 had increases. The explanations for these larger changes is the same for this group as for the poverty-level married couples—that is, "tax creep" for States showing increases, and more general rate schedule changes for States showing decreases. The change in percentage share of income varies by State. While 29 States went up, 16 States declined and 6 States remained the same.

State sales taxes

Forty-six States (including the District of Columbia) collect a general sales tax on goods and certain services sold in their States but have widely varying treatment of certain types of consumer expenditures. For example, while one State might exempt food from sales tax, another might simply apply a rate different from its general sales tax.

GAO's analysis of estimated sales tax expenditures examined married-couple families of four and elderly individuals only at the poverty level (see tables 9 and 11). The results of these computations are similar for the two groups, except that estimated sales tax was a smaller proportion of family income for elderly individuals than for the families. This was primarily because of their different patterns of taxable expenditures.[3] For elderly individuals, the proportion of income paid in sales taxes changed from an estimated range of 0.9 to 3.5 percent of income in 1980 to a range of 1.3 to 4.1 percent in 1988. For married-couple families, the range changed from an estimated 1.1 to 4.1 percent of income in 1980 to 1.6 to 4.9 percent for 1988.

---

[2] Throughout this analysis, the potential for negative tax liability, i.e., through refundable tax credits, is ignored.

Most States would have required both elderly individuals and married-couple families of four at the poverty level to pay more of their incomes in sales tax in 1989 than in 1980 (30 of 46 taxing States for the elderly individuals and 28 for married-couple families). The greatest change in estimated sales tax between 1980 and 1988 was 2.0 percent of income. Only five and six States had estimated changes of 1.0 percent or more for elderly individuals and for married-couple families, respectively. Few States showed decreases in their estimated sales tax burden (4 of 46 for elderly individuals and 5 for married-couple families).

In general, the increased shares of income estimated for sales tax payments reflect States' increases in their general sales tax rate. However, increases in the estimated share paid for sales taxes correspond, in one State, to the elimination of exemptions and, in another, to an increase in the special tax rate for electricity and gas. Reductions in estimated sales taxes correspond to a general rate reduction in one State and the addition of exemptions for food, drugs, utilities, or clothing in the others. Exemptions were added in four other States but were offset by general tax rate increases.

Summary

In general, the poor were likely to pay a greater share of their income in sales taxes than they paid in income taxes. For the elderly, this was primarily due to the favorable income tax treatment afforded to Social Security benefits. However, while fewer States in 1988 than in 1980 would tax the income of poverty-level married-couple families, most of the States would have increased the share of income these families were likely to pay in sales taxes. Overall, total State income and sales taxes as a share of income increased in 29 States and stayed even in 1 State.

Study methodoloy

These analyses are based entirely on unpublished GAO estimates of the tax payments of hypothetical elderly individuals and married-couple families of four. In these analyses, income and expenditure patterns for each family type at each income level were held constant across States and tax years, ignoring variations in these patterns within and across individual States and over time. This approach was adopted in order to highlight the effects of tax structure changes. Thus, the tax estimates reported below do not represent the actual taxes paid by families but, rather, are based on assumptions about various aspects of their income and expenditures and are intended to illustrate the effects of the major changes that have occurred in tax structures.

---

[3] These analyses assume the same expenditure patterns for each family type for 1980 and 1988. As a result, they do not reflect changes in prices or purchasing patterns across time. Moreover, because national average values of expenditures were used to control for variations in purchasing patterns and prices across (and within) States, the sales tax estimates reported below only approximate actual burdens.

Family income is measured on a cash receipt basis, a definition generally consistent with the measure of income used by the States' income tax systems. Family income equals the receipt of wages, salaries, self-employment, interest and dividends, government cash transfers, and cash pension benefits. It excludes capital gains, employer contributions to pension funds, in-kind government transfer payments, and other noncash income.

State income taxes were calculated at two income levels: 100 percent and 150 percent of the poverty level. The 1988 poverty levels for the family types were deflated using the CPI-U-X1 series to derive comparable 1980 poverty levels. Taxes were calculated on the basis of typical profiles of cash income sources and amounts for each family type at each income level in 1988. Profiles of tax-exempt and tax-liable income for poor and near-poor elderly individuals and two-parent families of four were derived from the average values reported by similar families in the Current Population Survey (CPS). The family income profiles used for the figures reported were as follows:

—elderly individuals at poverty level (totaling $3,987 for 1980 and $5,674 for 1988): 92.2 percent tax-exempt transfers (primarily from Social Security) and 7.8 percent other private income;

—elderly individuals at 150 percent of poverty ($5,981 for 1980 and $8,511 for 1988): 75-6 percent tax-exempt transfers, 24.4 percent from other income sources;

—married couples at poverty level ($8,497 for 1980 and $12,092 for 1988): 89.4 percent earnings and other income, with the remainder from tax-exempt public transfer payments;

—married couples at 150 percent of poverty ($12,746 for 1980 and $18,138 for 1988): 96.2 percent earnings and other private income, 3.8 percent from tax-exempt transfer payments.

To determine the 1980 and 1988 income tax liability for each family type, each State's applicable personal exemptions, standard deductions, tax rates and tax credits in those years were employed as reported in the Advisory Commission on Intergovernmental Relations (ACIR) publication, "Significant Features of Fiscal Federalism" (1979-80 and 1989 editions). Some States have provisions that would reduce the tax liability of low-income taxpayers, such as a sales or low-income tax credit, or special no-tax threshold; many States provided additional exemptions or tax credits to elderly taxpayers. These features were incorporated in the State income tax calculations where information was available. In a few states where ACIR data were insufficiently detailed, supplemental information was obtained from the State income tax models developed by the Census Bureau. (These States are noted in tables 1 and 2.) Detailed information was unavailable to incorporate other identified features such as earned-income tax credits, property tax credits or minimum standard deductions. Similarly, since detailed information on 1980 income exclusions (such as for interest or pensions) comparable to that for 1988 was not available, the income taxes in both years may be overestimated with an unknown impact on estimates of net change.

State sales taxes were calculated for each family type at the poverty level only, in both years, based on the expenditures of similar family types in 1988 and on the general sales tax rate and major categories of exemptions (food, drugs, electricity and gas, and clothing) reported by ACIR for each State in 1980 and 1988. Because exemptions of gas, electricity, and clothing from sales tax were not reported by ACIR until 1984, the 1980 sales tax estimates are based on their tax-exempt status in 1984.

Because of the lack of detailed published information on which expenditures are subject to tax, the inclusion of all items that might be bought by an individual consumer in a store (plus certain services such as dry cleaning) may have resulted in overestimates of the taxes paid. State excise (gasoline, tobacco, and alcohol), local (property, sales, income) and other taxes that may have important effects on poor families' disposable income were not included in this analysis. (Note that District of Columbia figures, however, include both local sales and income taxes.)

TABLE 9.—STATE INCOME AND SALES TAXES [1] FOR A POOR TWO PARENT FAMILY OF FOUR AND AS A PERCENT OF INCOME IN 1980 AND 1988, BY STATE

State	Income tax		Sales tax		Taxes expressed as a percent of income					
					Income tax		Sales tax		Income and sales tax	
	1980	1988	1980	1988	1980	1988	1980	1988	1980	1988
Alabama	$80	$182	$280	$363	0.9	1.5	3.3	3.0	4.2	4.5
Alaska	2				0				0.0	0.0
Arizona	[3] 44	29	280	373	0.5	0.2	3.3	3.1	3.8	3.3
Arkansas	[2] 83	[2] 187	211	358	1.0	1.5	2.5	3.0	3.5	4.5
California	[3] 0	0	218	310	0	0	2.6	2.6	2.6	2.6
Colorado	[3] 44	0	139	198	0.5	0	1.6	1.6	2.2	1.6
Connecticut			337	412			4.0	3.4	4.0	3.4
Delaware	[3] 77	[3] 87			0.9	0.7			0.9	0.7
District of Columbia	125	0	262	442	1.5	0	3.1	3.7	4.6	3.7
Florida			183	442			2.2	3.7	2.2	3.7
Georgia	29	[3] 26	213	302	0.3	0.2	2.5	2.5	2.8	2.7
Hawaii	135	[2] 0	280	395	1.6	0	3.3	3.3	4.9	3.3
Idaho	0	0	192	452	0	0	2.3	3.7	2.3	3.7
Illinois	86	170	262	373	1.0	1.4	3.1	3.1	4.1	4.5
Indiana	85	232	207	373	1.0	1.9	2.4	3.1	3.4	5.0
Iowa	[3] 41	0	158	295	0.5	0	1.9	2.4	2.3	2.4
Kansas	[2] 45	[2] 0	192	358	0.5	0	2.3	3.0	2.8	3.0
Kentucky	140	[2] 330	231	329	1.6	2.7	2.7	2.7	4.4	5.4
Louisiana	0	0	139	260	0	0	1.6	2.2	1.6	2.2
Maine	23	0	231	329	0.3	0	2.7	2.7	3.0	2.7

TABLE 9.—STATE INCOME AND SALES TAXES [1] FOR A POOR TWO PARENT FAMILY OF FOUR AND AS A PERCENT OF INCOME IN 1980 AND 1988, BY STATE—Continued

State	Income tax		Sales tax		Taxes expressed as a percent of income					
					Income tax		Sales tax		Income and sales tax	
	1980	1988	1980	1988	1980	1988	1980	1988	1980	1988
Maryland	104	[2] 200	236	373	1.2	1.7	2.9	3.1	4.0	4.7
Massachusetts	[3] 151	0	199	283	1.8	0.0	2.3	2.3	4.1	2.3
Michigan	67	[2] 166	207	295	0.8	1.4	2.4	2.4	3.2	3.8
Minnesota	[2] [3] 183	[2] 0	157	336	2.2	0	1.9	2.8	4.0	2.8
Mississippi	0	0	201	382	0	0	2.4	3.2	2.4	3.2
Missouri	[2] 13	50	349	593	0.2	0.4	4.1	4.9	4.3	5.3
Montana	105	133			1.2	1.1			1.2	1.1
Nebraska	0	[2] 58	211	295	0	0.5	2.5	2.4	2.5	2.9
Nevada			96	372			1.1	3.1	1.1	3.1
New Hampshire									0.0	0.0
New Jersey	69	136	199	336	0.8	1.1	2.3	2.8	3.2	3.9
New Mexico	[2] [3] 0	[2] 0	266	474	0	0	3.1	3.9	3.1	3.9
New York	0	[2] 9	183	260	0	0.1	2.2	2.2	2.2	2.2
North Carolina	[3] 112	[2] 186	192	273	1.3	1.5	2.3	2.3	3.6	3.8
North Dakota	[2] 30	0	183	356	0.4	0	2.2	2.9	2.5	2.9
Ohio	24	5	183	329	0.3	0	2.2	2.7	2.4	2.8
Oklahoma	23	[2] 44	134	358	0.3	0.4	1.6	3.0	1.8	3.3
Oregon	[2] 119	[2] 107			1.4	0.9			1.4	0.9
Pennsylvania	[2] 164	[2] 227	236	388	1.9	1.9	2.8	3.2	4.7	5.1
Rhode Island	0	0	236	336	0	0	2.8	2.8	2.8	2.8

South Carolina	85	0	276	452	1.0	0	3.2	3.7	4.2	3.7
South Dakota			349	395			4.1	3.3	4.1	3.3
Tennessee			294	490			3.5	4.1	3.5	4.1
Texas			183	390			2.2	3.2	2.2	3.2
Utah	[2] 113	[2] 0	258	472	1.3	0	3.0	3.9	4.4	3.9
Vermont	[2] 0	[2] 0	139	260	0	0	1.6	2.2	1.6	2.2
Virginia	[2] 88	[2] 117	192	320	1.0	1.0	2.3	2.6	3.3	3.6
Washington			207	474			2.4	3.9	2.4	3.9
West Virginia	91	84	192	390	1.1	0.7	2.3	3.2	3.3	3.9
Wisconsin	[2] 77	[2] 0	183	329	0.9	0	2.2	2.7	3.1	2.7
Wyoming			211	302			2.5	2.5	2.5	2.5

---

[1] Tax estimates are reported in unadjusted dollars and are based on the personal exemptions, standard deductions, tax rate schedules and tax credits reported by ACIR. Provisions which would reduce the liability of low-income taxpayers were incorporated in some States where information was sufficient to do so.

[2] This figure does not take into account a special low-income tax provision in this State.

[3] Census Bureau data were used to provide details unavailable in the ACIR publications.

TABLE 10.—STATE INCOME TAX AND PERCENTAGE SHARE OF INCOME PAID BY A NEAR-POOR TWO-PARENT FAMILY OF FOUR, 1980 and 1988 [1]

State	Income taxes		As a percent of income	
	1980	1988	1980	1988
Alabama	$261	$414	2.0	2.3
Alaska	150		1.2	
Arizona	[3] 201	143	1.6	0.8
Arkansas	[2] 265	[2] 500	2.1	2.8
California	[3] 99	122	0.8	0.7
Colorado	[3] 190	243	1.5	1.3
Connecticut				
Delaware	[3] 266	[3] 410	1.8	2.3
District of Columbia	429	725	3.4	4.0
Florida				
Georgia	151	[3] 273	1.2	1.5
Hawaii	453	[2] 486	3.6	2.7
Idaho	109	178	0.9	1.0
Illinois	207	342	1.6	1.9
Indiana	176	464	1.4	2.6
Iowa	[3] 212	585	1.7	3.2
Kansas	[2] 134	[2] 233	1.1	1.3
Kentucky	372	[2] 702	2.9	3.9
Louisiana	46	120	0.4	0.7
Maine	86	208	0.7	1.1
Maryland	314	[2] 496	2.5	2.7
Massachusetts	[3] 410	563	3.2	3.1
Michigan	288	[2] 481	2.3	2.7
Minnesota	[2] [3] 587	[2] 292	4.6	1.6
Mississippi	0	53	0	0.3
Missouri	[2] 122	305	1.0	1.7
Montana	369	385	2.9	2.1
Nebraska	16	[2] 274	0.1	1.5
Nevada				
New Hampshire				
New Jersey	165	273	1.3	1.5
New Mexico	[2] [3] 0	[2] 112	0	0.6
New York	278	[2] 277	2.2	1.5
North Carolina	[3] 367	[2] 673	2.9	3.7
North Dakota	[2] 108	102	0.8	0.6
Ohio	72	182	0.6	1.0
Oklahoma	89	[2] 231	0.7	1.3
Oregon	[2] 351	[2] 622	2.8	3.4
Pennsylvania	[2] 270	[2] 371	2.1	2.0
Rhode Island	143	[2] 147	1.1	0.8
South Carolina	258	154	2.0	0.8

TABLE 10.—STATE INCOME TAX AND PERCENTAGE SHARE OF INCOME PAID BY A NEAR-POOR TWO-PARENT FAMILY OF FOUR, 1980 and 1988 [1]—Continued

State	Income taxes		As a percent of income	
	1980	1988	1980	1988
South Dakota				
Tennessee				
Texas				
Utah	[2] 300	[2] 280	2.4	1.5
Vermont	[2] 173	147	1.4	0.8
Virginia	[2] 271	[2] 458	2.1	2.5
Washington				
West Virginia	200	290	1.6	1.6
Wisconsin	[2] 379	[2] 329	3.0	1.8
Wyoming				

---

[1] Tax estimates are reported in unadjusted dollars and are based on the personal exemptions, standard deductions, tax rate schedules and tax credits reported by ACIR. Provisions which would reduce the liability of low-income taxpayers were incorporated in some states where information was sufficient to do so.

[2] This figure does not take into account a special low-income tax provision in this state.

[3] Census Bureau data were used to provide details unavailable in the ACIR publications.

TABLE 11.—STATE SALES TAX AND PERCENTAGE SHARE OF INCOME PAID BY A POOR ELDERLY INDIVIDUAL, 1980 AND 1988 [1]

State	Sales taxes		As a percent of income	
	1980	1988	1980	1988
Alabama	112	139	2.8	2.5
Alaska				
Arizona	83	147	2.1	2.6
Arkansas	85	139	2.1	2.5
California	81	116	2.0	2.0
Colorado	52	74	1.3	1.3
Connecticut	125	156	3.1	2.8
Delaware				
District of Columbia	103	175	2.6	3.1
Florida	69	175	1.7	3.1
Georgia	90	121	2.3	2.1
Hawaii	119	160	3.0	2.8
Idaho	74	172	1.9	3.0
Illinois	110	147	2.8	2.6
Indiana	83	147	2.1	2.6
Iowa	63	119	1.6	2.1
Kansas	74	139	1.9	2.5
Kentucky	86	122	2.1	2.1
Louisiana	52	98	1.3	1.7
Maine	86	122	2.1	2.1

TABLE 11.—STATE SALES TAX AND PERCENTAGE SHARE OF INCOME PAID BY A POOR ELDERLY INDIVIDUAL, 1980 AND 1988 [1]—Continued

State	Sales taxes		As a percent of income	
	1980	1988	1980	1988
Maryland	91	147	2.3	2.6
Massachusetts	75	107	1.9	1.9
Michigan	83	119	2.1	2.1
Minnesota	61	127	1.5	2.2
Mississippi	139	235	3.5	4.1
Missouri	77	147	1.9	2.6
Montana				
Nebraska	85	119	2.1	2.1
Nevada	35	139	0.9	2.5
New Hampshire				
New Jersey	75	127	1.9	2.2
New Mexico	112	200	2.8	3.5
New York	69	98	1.7	1.7
North Carolina	74	105	1.9	1.9
North Dakota	69	133	1.7	2.3
Ohio	69	122	1.7	2.1
Oklahoma	53	139	1.3	2.5
Oregon				
Pennsylvania	89	157	2.2	2.8
Rhode Island	89	127	2.2	2.2
South Carolina	98	172	2.5	3.0
South Dakota	139	160	3.5	2.8
Tennessee	115	189	2.9	3.3
Texas	69	145	1.7	2.6
Utah	102	175	2.5	3.1
Vermont	52	98	1.3	1.7
Virginia	74	122	1.9	2.2
Washington	77	188	1.9	3.3
West Virginia	74	145	1.9	2.6
Wisconsin	86	122	2.1	2.1
Wyoming	85	121	2.1	2.1

[1] Tax estimates are reported in unadjusted dollars.

THE DISTRIBUTION OF FEDERAL TAXES: 1977–1992

Summary

The highest income one-fifth of the population will pay a smaller percent of their income in taxes in 1992 than in 1977 while the bottom 80 percent will pay more of their income in taxes in 1992 than in 1977. Taxpayers in the very highest income categories (top 1 and top 5 percent) show the largest reduction in taxes as a percent of income.

Over the same period, the incomes of the top 20 percent of the families rose faster than average family income. The incomes of the bottom 40 percent of families fell in real (adjusted for inflation) terms, and relative to everyone else. Because the incomes of the top 20 percent of families rose faster than average, they earned a higher share of overall family income in 1992 than in 1977. As a result, they paid a higher share of total Federal taxes. But they paid less of their income in taxes in 1992 than in 1977; therefore, their share of total family income grew faster than their share of total Federal taxes paid.

What has caused the Federal tax system to become less progressive than it was in 1977? That is, what has caused taxes to fall as a percent of the income of high-income families, and rise as a percent of income of middle-income families? This trend has two principal causes. First, while income taxes have fallen as a percent of income for all households, payroll taxes have increased as a percent of income for all households. Payroll taxes represent a higher share of income for low- to middle-income households than for high-income households. This is because payroll taxes are levied only on earned income up to a dollar cap. In fact, it is only for the top 20 percent of households that income taxes exceed payroll taxes. Accordingly, for the top 20 percent of households, income tax reductions have more than offset payroll tax increases. Conversely, for low- and moderate-income households, significant payroll tax increases have more than offset modest income tax reductions.

Second, while the progressivity of the income tax has stayed roughly constant since 1977, this is not true for very high income families (the top 1 percent). For these households, income taxes have fallen as a percent of income more than for other households. The net result of these two factors is that for households at the very top of the income scale, total taxes have fallen as a percent of income more than for other households—and even more than for other households in the top 20 percent.

Overview of Tables

Between 1977 and 1992, the percent of income paid in Federal taxes—or "effective tax rate"—by the highest income one-fifth of American families fell by 17.6 percent. Table 14 shows that the higher the average income of the household, the greater the percentage reduction in effective tax rates. For example, the top 1 percent of families paid 35.5 percent of their income in Federal taxes in 1977, and 29.3 percent in 1992—a percentage reduction of 18 percent. The top 10 percent of families paid 4 percent less of their income in taxes in 1992 than in 1977; the top 5 percent, 8 percent less.

During this period, table 15 shows that the average real income of the top 20 percent of American families grew by 33.1 percent; the average income of all families together grew at about half this rate, or 16.1 percent. The higher the income category of household, the greater the percentage increase in average real income. For example, the average income of the top 1 percent of households grew by 113.0 percent during the period, and the average income of the top 5 percent of households grew by 57.5 percent.

The average income of the bottom 20 percent of families fell in absolute real terms, and relative to the rest of the population. For example, while average family income grew 16.1 percent between 1977 and 1992, the income of the bottom one-fifth fell by 10.1 percent.

The two trends summarized in tables 14 and 15 are depicted graphically in chart 1. For example, chart 1 illustrates that taxes for the top 1 percent of households fell by 17.6 percent between 1977 and 1992, while average real household income for that same group grew by 113.0 percent.

Table 17 shows what was happening to different types of Federal taxes during the period. From table 17, it can be seen that for all household income categories, effective payroll tax rates increased, while effective income tax rates generally fell (or stayed about the same). Payroll taxes are a relatively larger percentage of income for low-income taxpayers than are income taxes. Thus, for low-income taxpayers, the rise in payroll tax rates more than offset the decrease in income tax rates. Therefore, the bottom four quintiles (lowest 80 percent) experienced an increase in overall Federal taxes as a percent of income. For high-income taxpayers, the reverse was true. The decline in effective income tax rates more than offset increases in payroll taxes; the top one-fifth of American households therefore experienced a reduction in the percentage of their income paid in Federal taxes.

Not all of the change in effective tax rates is caused by changes in tax law. Table 28 shows the effect of applying the tax laws in effect in 1977, 1980, 1985, and 1988, adjusted for changes in income since those years, to the 1992 income distribution and demographic composition. When the effect of changes in income are eliminated, the drop in the effective tax rate of the top 1 percent of households since 1977 is much smaller, while the increase in effective tax rates for most other groups is larger. Most of the difference between the actual 1977 rates and those that would result from returning to 1977 law is in the corporate income tax. Effective corporate income tax rates dropped between 1977 and 1992 because corporate profits are a much smaller fraction of income in 1992 than they were in 1977 and not because corporate taxes as a percent of profits changed.

Table 29 shows effective tax rates for different types of taxes for the top 1 percent of households and for the middle quintile. The tax rates are shown both at their actual levels and at the rates that would result from applying previous years' laws to 1992 income and demographics. The two measures of the change in total tax rates since 1977 are quite different. For example, total Federal taxes are projected to fall from 35.6 percent of income in 1977 to 29.3 percent in 1992 for the top 1 percent of the population. However, when the 1977 tax system is applied to 1992 incomes and demographics, the total Federal tax rate falls from 37.4 percent of income (1977 tax system) to 29.3 percent of income.

For the middle income quintile, actual total Federal tax rates increased slightly between 1977 and 1992: from 19.5 percent of income to 19.7 percent of income. However, when the 1977 tax system is applied to 1992 income and demographics, changes in tax policy increased effective total Federal tax rates from 16.9 percent (1977 tax system) to 19.7 percent of income.

Table 20 shows tax burdens for different types of families. From table 20 it can be seen that Federal taxes fell as a percent of income for elderly households in all income categories between 1977 and 1990. For families with children, effective tax rates rose for the middle 60 percent and top one-fifth, but fell for the bottom one-fifth.

While effective tax rates for the top one-fifth of American households increased, their share of *total* Federal taxes paid also went up between 1977 and 1990. Table 21 shows that the top 20 percent of households paid 55.7 percent of all Federal taxes in 1977, and 60.5 percent in 1992—an increase of almost five percentage points. Conversely, the share of total taxes paid by the bottom 80 percent of households went down during the period. (This had to happen, by definition: since the share of total taxes paid by the top 20 percent went up, the share of everyone else had to fall.)

Table 22 shows that the share of total income earned before taxes by the top 20 percent of households rose by 5.3 percentage points. The share of total pretax income by the bottom 80 percent fell. The increase in the share of total family income earned by the top 20 percent of families is an outcome of the trend described in table 15. The income of the top one-fifth of families grew faster than the national average (table 15); therefore, their percent of overall income also grew relative to everyone else. Conversely, the income of the bottom 80 percent of families grew slower than the national average, so their share of overall income fell.

A comparison of tables 21 and 22 shows that the share of total taxes paid by the top 20 percent of families grew during the period, but not as rapidly as their share of total income. (This is because the effective tax rates of households in this income category fell during the period.) Table 23 shows the combined results of these two trends: the share of *after-tax* income for the top 20 percent of families rose faster than their share of pretax income.

Study Methodology

The methodology used for these tables is based upon three CBO studies: "The Changing Distribution of Federal Taxes: 1975–1990" issued in October, 1987 and "The Changing Distribution of Federal Taxes: A Closer Look at 1980" issued in July 1988. The reader is referred to those studies for greater detail about methodology.

In these CBO studies, combined Federal taxes include individual and corporate income taxes, social insurance payroll taxes, and excise taxes except for the windfall profit tax. Although Federal tax payments are made by persons, corporations, and noncorporate employers, the economic burden of all taxes ultimately rests with families and individuals. Economists speak of the reduction in family income or purchasing power as the incidence of a tax. The incidence of some taxes, particularly the corporate income tax, is uncertain, and remains a controversial issue. The following incidence assumptions were used in the tables.

—The individual income tax burden is attributed to the families who directly pay the tax. The study assumes no shifting of the tax among families.

—The social insurance payroll tax burden is allocated to employee compensation. The portion of the payroll tax collected from employers is assumed to be shifted back onto employees in the form of lower wages.

—Excise taxes are assumed to be passed forward to individual consumers in higher prices on goods subject to the tax.

—Although the corporate income tax is collected from corporations, families are assumed ultimately to bear its economic burden. Economists disagree, however, about who is affected by the corporate income tax, employees of the corporation or shareholders. The tables that follow assume that half of the corporate income tax is allocated to capital income and half to labor income. The method of allocation does not affect the main conclusions about how the distribution of the tax burden among income classes has changed over time.

These tables do not attempt to allocate the distributional effects of general government spending. In comparing the distribution of Federal taxes in different years, shifts in the distribution of general expenditures between those years are ignored. The CBO studies also separate the distribution effects of taxes from the effects of expenditures significantly related to those taxes. Social Security revenues are thus implicitly treated as independent of benefit payments.

Family income is measured on a cash receipt basis, a definition generally consistent with the measure of income used by the Federal tax system. Family income equals the sum of wages, salaries, self-employment income, personal rents, interest, dividends, government cash transfers, cash pension benefits and realized capital gains. Family income excludes accrued but unrealized capital gains, employer contributions to pension funds, in-kind government transfer payments, and other noncash income. Because income is measured before reductions for any Federal taxes, employer contributions for Federal social insurance and Federal corporate profits taxes are added to family income. Family incomes are put in constant dollars by the CPI-X1 price index.

Data Sources and Presentation of Results

Distributions of family income for 1977, 1980, 1985, 1988 and the projected distribution in 1992 are based on data from four sources. The primary source is the March Current Population Survey (CPS) for 1978, 1981, 1986, and 1989. The CPS is a monthly survey of approximately 60,000 families, conducted by the Bureau of the Census. Each March, the survey collects detailed information on family characteristics and family income in the previous calendar year. The reported data on income from taxable sources from the CPS files were adjusted for consistency with reported income from Statistics of Income (SOI) samples for calendar years 1977, 1980, 1985 and 1988. The SOI is an extensive annual sample of actual individual income tax returns. Data on consumer expenditures were taken from the 1980–88 Consumer Expenditure Survey (CES) Interview Surveys. The CES Interview Survey is a quarterly panel survey conducted by the Bureau of Labor Statistics. The survey collects detailed data on household expenditures over a 12-month period. CES data from 1980 and 1981 were adjusted to 1977 levels by changes in per capita expenditures of certain types as reported in the National Income and Product Accounts.

Many people incur "paper losses" for tax purposes. In order to approximate better the economic income of families, rental losses and most partnership losses were not subtracted from family income. All losses of sole proprietorships were allowed.

Reported pre-tax family incomes were adjusted to include the amount of the employer share of the Social Security payroll tax, the unemployment insurance payroll tax, and the corporate income tax. The unemployment insurance payroll tax and the employer share of the Social Security payroll tax were allocated to the employee on whose behalf the taxes were paid.

Effective Federal tax rates—the percentage of family income paid in taxes—for people ranked in quintiles by their adjusted pretax family income are shown in table 14. People are assigned to quintiles or deciles based on family income divided by the poverty threshold for the appropriate family size. Twenty percent of the population are in each quintile for each year. They will represent a different percentage of families. Families include both families and single individuals. Average incomes and tax rates for the lowest quintile or decile were calculated excluding families with negative or zero incomes. The poverty thresholds depend on family size, the age of the householder, and the number of children. The average thresholds for various family types are shown in the table below.

The poverty thresholds in table 31 of appendix I increase each year by the CPI-X1 consumer price index. Unlike last year's analysis, poverty thresholds do not vary by age of head. When these poverty thresholds are applied to incomes to obtain adjusted family income, the resulting adjusted income has been automatically adjusted for both price inflation (as measured by the CPI-X1) and family size.

Table 12 compares the income data from the tax model with the earlier results based on unadjusted Census data. Tax model data show more income than do the Census data, for three reasons:

1. The tax model adjusts data from the Census' Current Population Survey to correct for two shortcomings: the underreporting of income by survey respondents and top-coding of incomes in the data publicly available for analysis. The adjustments are based on data from the Statistics of Income (SOI), which are in turn derived from information on tax returns.
2. The tax model imputes realized capital gains to families and individuals; the Census data exclude all capital gains.
3. Because the tax model measures income before all taxes—including those not paid directly—it counts as income both payroll taxes paid by employers and corporate income tax payments. The tax model numbers shown in table 12 have been adjusted to take out this extra income.

Given these differences between the tax model data and the Census data, the differences between incomes from the two studies shown in table 12 are understandable and the two analyses produce reasonably consistent estimates. Because of both the adjustments to income and the imputation of realized capital gains, however, the results of the tax model provide a better indication of how incomes have changed for the wealthiest families.

TABLE 12.—COMPARISON OF CENSUS BUREAU AND CBO TAX MODEL DATA

All families (by income group)	Pretax census [1]	Pretax census SOI [2]	After-tax census SOI [3]	Pretax census [4]	After-tax census [5]
	1977	1977	1977	1979	1979
Lowest	0.89	0.97	0.89	0.90	0.96
Second	1.96	2.12	1.81	2.06	1.89
Middle	2.91	3.21	2.60	3.07	2.67
Fourth	4.07	4.53	3.54	4.32	3.63
Highest	7.02	9.11	6.61	7.39	5.85
Average	3.37	4.00	3.09	3.55	3.00
	1988	1988	1988	1989	1989
Lowest	0.85	0.88	0.80	0.86	0.93
Second	2.08	2.08	1.76	2.09	1.90
Middle	3.25	3.34	2.69	3.27	2.84
Fourth	4.72	4.97	3.86	4.77	4.01
Highest	8.60	11.94	8.83	8.84	7.04
Average	3.90	4.63	3.57	3.97	3.35
Percent change					
Lowest	−4.5	−9.3	−10.1	−4.3	−2.1
Second	6.1	−1.9	−2.8	1.3	0.5
Middle	11.7	4.0	3.5	6.7	6.4
Fourth	16.0	9.7	9.0	10.5	10.6
Highest	22.5	31.1	33.6	19.6	20.4
Average	15.7	15.8	15.5	11.8	11.6

[1] Table 34, appendix I.
[2] Table 15, appendix J.
[3] Table 16, appendix J.
[4] Table 30, appendix I.
[5] Table 37, appendix I.

Source: Congressional Budget Office.

Table 13 shows the sources of income of families with the highest incomes in 1977, 1980, and 1988. Incomes are shown separately for the top 1 percent, the 96th through 99th percentiles, and the 91st through 95th percentiles. The same information is shown for families in the remaining 90 percent of the income distribution.

Average pretax income, adjusted for inflation with CPI-X1, grew much faster for the top 1 percent of the population than for any other group since either 1977 or 1980. Wages and salaries and capital gains realizations grew especially quickly for the top 1 percent, but income from each source grew faster for the top 1 percent than it did for the other groups. Wages and salaries are the largest source of growth for the other two groups of high-income families. Transfer income of the high-income families grew because the higher incomes of elderly families has pushed them into the high-income categories.

TABLE 13.—SOURCES OF INCOME OF HIGH-INCOME FAMILIES, 1977, 1980, AND 1988

[In constant 1992 dollars]

	Wages and salary [1]	Self-employment	Capital gain realizations [2]	Other investment income [2]	Transfer income	Other income	All income
Top 1 percent:							
1977	107,454	52,164	71,780	76,592	2,710	3,826	314,526
1980	121,341	39,941	91,236	84,614	2,585	3,893	343,610
1988	237,183	84,403	155,690	129,912	3,045	6,981	617,214
1977 to 1988 change	129,729	32,240	83,910	53,319	335	3,155	302,688
Percent change	120.7	61.8	116.9	69.6	12.4	82.5	96.2
96 to 99 percentile:							
1977	65,864	14,218	7,399	15,173	2,054	3,237	107,945
1980	68,398	10,748	7,310	17,436	2,310	3,349	109,551
1988	82,220	12,694	8,411	20,313	2,427	6,489	132,553
1977 to 1988 change	16,356	−1,524	1,012	5,139	373	3,252	24,608
Percent change	24.8	−10.7	13.7	33.9	18.2	100.5	22.8
91 to 95 percentile:							
1977	58,289	5,559	2,155	6,405	1,864	2,253	76,525
1980	57,503	4,134	2,269	7,594	2,013	2,363	75,876
1988	65,369	4,255	1,861	8,243	2,214	3,723	85,664
1977 to 1988 change	7,080	−1,304	−295	1,838	350	1,470	9,139
Percent change	12.1	−23.5	−13.7	28.7	18.8	65.2	11.9
Bottom 90 percent:							
1977	24,123	1,119	299	1,817	3,149	1,146	31,653
1980	23,228	1,006	316	1,886	3,151	1,225	30,812
1988	23,281	1,041	252	2,125	3,123	1,847	31,669
1977 to 1988 change	−842	−78	−47	308	−26	701	16
Percent change	−.3.5	−7.0	−15.7	17.0	−0.8	61.2	0.1

---

[1] Includes imputed employer payroll taxes and part of corporate income tax.

[2] Includes part of corporate income tax.

Real income for the lowest 90 percent of the population grew 0.1 percent between 1977 and 1988 and 2.8 percent between 1980 and 1988. Two sources account for most of the increase—investment income other than capital gains and other income (primarily pensions).

DESCRIPTION OF TABLES

Table 14

Table 14 compares the total Federal effective tax rates for all families. In 1992, total Federal taxes are projected to be 8.6 percent of income for the lowest 20 percent of the population, while they are estimated to be 26.8 percent for the highest. From 1977 to 1992, the tax rate is estimated to fall by 8.0 percent for the lowest quin-

tile. In addition, the tax rate is expected to fall by 1.4 percent for the highest quintile and by 17.6 percent for the richest 1 percent of the population.

Table 15

Table 15 compares the adjusted pretax family income for all families, with income expressed as multiples of the poverty thresholds and percentage changes in real income adjusted for inflation. In 1992, average adjusted pretax family income is estimated to be 87 percent of the poverty threshold for the lowest 20 percent of the population, while it is projected to be an average of 12.12 times poverty for the highest. From 1977 to 1992, real income is projected to fall by 10.0 percent for the lowest quintile. By contrast, it is expected to rise by 33.1 percent for the highest.

Chart 1 graphically depicts the percentage change from 1977 to 1992 in real income and Federal tax rates (tables 14 and 15). For the lowest 20 percent of the population, real income fell by 10.1 percent, while the total Federal tax rate fell by 8.0 percent. By contrast, for the richest 1 percent of the population, real income rose by 113.0 percent, while the total Federal tax rate fell by 17.6 percent.

Table 16

Table 16 compares the average post-tax family income for all families, with incomes expressed as multiples of the poverty thresholds and percentage changes in real income adjusted for inflation. The 1992 average post-tax family income for the poorest 20 percent was estimated to be 80 percent of the poverty threshold. Average post-tax family income was almost 9 times the poverty threshold for the richest 20 percent of the population and over 50 percent times the poverty line for the richest 1 percent.

Table 17

Table 17 describes the Federal effective tax rates for different kinds of taxes for all families. In 1977, for the middle quintile in income of the population, the individual income tax rate was 6.9 percent of income. Overall, for the total U.S. population it was 11.1 percent. From 1977 to 1992, the tax rate for the middle group declined by 8.6 percent.

In 1977, for the middle quintile, the social insurance tax rate was 8.1 percent of income. Overall, for the total U.S. population it was 6.5 percent. From 1977 to 1992, the tax rate for the middle group rose by 27.1 percent.

Table 18

Table 18 shows the changes in individual income tax rates and social insurance. When the earned income tax credit (EITC) is counted as part of social insurance taxes. In other tables, the EITC is generally accounted for in individual income taxes.

Table 19

Table 19 illustrates the average real pretax and after-tax income for all families. Because the lowest quintile does not include those people with negative incomes, the third panel shows fewer people in that group than in others.

Table 20

Table 20 presents data with respect to total Federal effective tax rates by family type. In 1992, for families with children in the lowest 20 percent of income of the total U.S. population, total Federal taxes are estimated to be 7.7 percent of income; 21.7 percent for the middle quintile, and 27.5 percent for the highest. From 1977 to 1992, the total Federal effective tax rate is expected to fall by 36.0 percent for families with children in the lowest quintile of the total U.S. population and rise by 5.0 percent for the middle quintile. For the highest quintile, it is expected to rise by 3.0 percent.

In 1992, for elderly households in the lowest 20 percent of income of the total U.S. population, total Federal taxes are estimated to be 3.0 percent of income; 8.0 percent for the middle quintile, and 23.3 percent for the highest. From 1977 to 1992, the total Federal effective tax rate is expected to fall by 43.0 percent for elderly households in the lowest quintile of the total U.S. population; by 19.0 percent for those in the middle quintile, and face no change in the highest. Middle income elderly rates are considerably less than tax rates for the middle quintile for nonelderly families.

In 1992, for nonelderly households without children in the lowest 20 percent of income of the total U.S. population, total Federal taxes are expected to be 15.0 percent of income; 22.4 percent for the middle quintile, and 26.7 percent for the highest. From 1977 to 1992, the total Federal effective tax rate is expected to rise by 24.0 percent for nonelderly households without children in the lowest quintile of the total U.S. population, by 7.0 percent in the middle quintile, and to fall by 2.0 percent in the highest quintile.

In 1992, for all families in the lowest 20 percent in income of the total U.S. population, total Federal taxes are projected to be 8.6 percent of income; 19.7 percent for the middle quintile, and 26.8 percent for the highest. The reader is referred to table 14 for these figures.

Table 21

Table 21 compares the share of total Federal taxes paid by all families, from lowest to highest quintiles. In 1992, families in the lowest 20 percent in income of the total U.S. population are projected to pay 1.3 percent of the total tax burden, while the highest quintile will pay 60.5 percent. From 1985 to 1992, the tax burden of the lowest 20 percent in income of the total U.S. population is projected to fall by 33.5 percent, while it will rise by 8.6 percentage points for the highest quintile.

Table 22

Table 22 describes shares of pretax income for all families, from lowest to highest quintiles. In 1977, families in the lowest 20 percent in income of the total U.S. population received 4.9 percent of total pretax income, while the highest quintile acquired 46.6 percent. From 1977 to 1992, the share of pretax income of families in the lowest quintile dropped by 26.1 percent, while the share of the highest quintile rose by 12.8 percent.

Table 23

Table 23 describes shares of after-tax income for all families, from lowest to highest quintiles. In 1977, families in the lowest 20 percent in income of the total U.S. population received 5.7 percent of total after-tax income, while the highest quintile acquired 44.0 percent. From 1977 to 1992, the share of after-tax income of families in the lowest quintile dropped by 24.9 percent, while the share of the highest quintile rose by 14.1 percent.

Chart 2 graphically depicts shares and changes in shares of after-tax income of all families, from 1977 to 1992 (refer to table 23). The growth in the share of after-tax income for the highest 1 percent of the total U.S. population between 1977 and 1992 is projected to be more than the entire share of after-tax income of the lowest quintile.

Table 24

Table 24 illustrates shares of tax burdens for different kinds of taxes for all families. In 1985, the second lowest 20 percent in income of the total U.S. population paid 3.4 percent of total individual income taxes, while the highest owed 68.2 percent.

Table 25

Table 25 illustrates total 1992 pretax income distributed in 1977, 1980, 1985, and 1988 according to 1992 income shares. The table shows that the top 1 percent is projected to have $271 billion more income in 1992 than they would be projected to have if their share of income were to remain the same as in 1977. In addition, the bottom 95 percent of the population lost in relative terms since 1977.

Tables 26 and 27

Tables 26 and 27 are similar to table 25 showing total 1992 Federal taxes and after-tax income distributed according to 1977, 1980, 1985, and 1988 effective tax rates (adjusted to 1992 levels) and after-tax income shares.

The distribution of effective tax rates can change between years due to changes in the tax law, changes in families' economic behavior in response to changes in the tax law, and changes in incomes for reasons independent of the tax law. It is nearly impossible to distinguish between income changes caused by the latter two reasons. By evaluating effective tax rates at constant income levels, the study attempts to isolate the effect of tax law changes, as opposed to income changes, on effective tax rates. Tables 28 and 29 isolate the effect of tax policy on Federal effective tax rates.

Table 28

Table 28 shows effective tax rates with income and demographics held constant at their 1992 levels. This effectively isolates tax policy to illustrate the changes in tax policy relative to income and demographics. Taxes for 1977, 1980, 1985, and 1988 were estimated by adjusting the Tax Code in effect in those years for income growth between those years and 1992. If incomes from all sources and at all income levels grew at the same rate from an earlier year to 1992 and if the demographic composition of the population did not change, the effective tax rates calculated for that year at 1992 levels would be the same as the actual effective rates for that year.

The individual income tax law for 1977, 1980, 1985, and 1988 at 1992 levels was simulated by indexing all dollar parameters in the Tax Code for those years by the change in income per family up to 1992, and then applying the "income-indexed" law to 1992 incomes. Social insurance taxes were simulated by using the payroll tax rate for earlier years and the maximum amount of earnings subject to tax indexed by the change in wages per family. Corporate taxes were simulated by assuming that corporate income tax revenue under a previous year's law would equal the same fraction of corporate profits in 1992 as it did in the earlier year. Excise taxes were simulated by applying excise tax rates for earlier years after adjusting those rates for income growth.

Using 1992 incomes and demographic characteristics had little effect on the overall tax rates for 1977 and 1988, but it reduces the 1980 and 1985 tax rates by over 1.0 percentage points.

Table 29

The change in the effective tax rate of the top 1 percent between 1985 and 1992 is quite different when income and demographics are held constant at their 1992 levels. Table 29 provides details on the tax rates of the top 1 percent and of the middle quintile, measured at actual and at 1992 levels. The largest difference between actual effective rates for 1985 and effective rates for 1985 law at 1992 income levels is in the individual income tax. The effective tax rate for 1985 at 1992 income levels is over 8 percentage points higher than the actual 1985 level.

This increase reflects a change in the composition of income for the top 1 percent between 1985 and 1992. In 1985 about one-third of the income of the top 1 percent came from realized capital gains. By 1992, that percentage is projected to fall to about 22 percent. Because capital gains were taxed at a lower rate than other income under 1985 tax law, applying 1985 law to income in a year in which the top 1 percent are projected to receive a smaller share of their income from capital gains (1992) yields higher effective tax rates than applying 1985 law to income in a year in which capital gains were a larger share of income (1985). The increase also reflects a similar change with respect to passive losses. In 1985 passive losses for the top 1 percent were a much higher percentage of total income than they were in 1992. Because passive losses were deductible under 1985 tax law, applying 1985 law to income in a year in which passive losses are projected to be a small percentage of income (1992) yields higher effective tax rates than applying 1985 law to income in a year in which passive losses were a larger percentage of income (1985).

This does lead to some confusion concerning the effects of tax reform on individual income taxes for the top 1 percent. Measured at current year income levels (the top bank in table 29), the effective individual income tax rate for the top 1 percent is projected to rise from 19.5 percent in 1985 to 23.7 percent by 1992. Measured at constant 1992 income levels, however, the effective individual income tax rate for the top 1 percent is projected to fall from 27.9

percent in 1985 to 23.7 percent by 1992. The difference illustrates the problem of interpreting the effects of tax changes before and after the fact. If, for example, the effective tax rate for 1985 and 1992 were compared at constant 1985 income levels, the projected increase between 1985 and 1992 would be much larger than 4.2 percentage points (the difference between 19.5 and 23.7). By 1992, the distribution and composition of income for the top 1 percent is projected to have changed from 1985—partially in response to the tax changes themselves—in ways that are likely to mitigate the tax increase.

In last year's Green Book, effective tax rates for 1977, 1980, and 1985 tax laws were evalulated at constant 1990 income levels. Projections at that time showed a greater similarity between the 1985 and 1990 distribution and composition of income for the top 1 percent than current projections show between 1985 and 1992. Thus, there was a smaller projected decrease in the effective income tax rate between 1985 and 1990 (evaluated at constant 1990 incomes) last year than there is between the effective rate for 1985 and 1992 (evaluated at constant 1992 incomes) in table 29.

Tables 30–31

Table 31 presents similar information to tables 28 and 29 for different types of families. Table 30 is for 1992 only and follows table 20.

COMPARISON OF PAYROLL AND INDIVIDUAL INCOME TAXES

Table 32

The last two columns of table 32 illustrate the percentage of families paying some taxes who pay larger Social Security taxes than income taxes. In 1992, this percentage will be 36.0 percent, if only the employee portion of the Social Security tax is counted. This percentage increases to 70.5 percent, if both the employer and employee portions of the Social Security tax are counted.

Table 33

Table 33 illustrates estimates of the number of families paying no tax, paying income tax only, or payroll tax only. In addition, for those families paying both payroll and income taxes, the table shows the number of families where the payroll tax is greater than the income tax. In one set of estimates (last two columns) only the employee share of the payroll tax is counted. In the preceding two columns both the employer and employee shares are counted.

Table 34

Table 34 shows the maximum income for various income groups by family size.

TABLE 14.—TOTAL FEDERAL EFFECTIVE TAX RATES FOR ALL FAMILIES

All families (by income group)	1977	1980	1985	1988	1992 [1]	Percentage change			
						1977–92	1985–92	1988–92	1977–88
Lowest quintile	**9.3**	8.1	10.3	9.3	8.6	−8.0	−16.7	−7.7	−0.3
Second quintile	15.4	15.6	15.8	15.9	15.6	1.2	−0.9	−1.5	2.7
Middle quintile	19.5	19.8	19.1	19.8	19.7	1.2	2.9	−0.4	1.6
Fourth quintile	21.8	22.9	21.7	22.4	22.2	1.8	2.4	−0.6	2.4
81 to 90 percent	24.0	25.3	23.4	24.6	24.7	2.8	5.2	0.2	2.6
91 to 95 percent	25.2	26.3	24.2	26.0	26.0	3.2	7.5	0.0	3.2
96 to 99 percent	27.0	27.9	24.3	26.5	27.1	0.4	11.6	2.2	−1.7
Top 1 percent	35.5	31.7	24.9	26.9	29.3	−17.6	17.8	9.0	−24.4
Overall	22.8	23.3	21.7	22.9	23.3	2.4	7.1	1.8	0.6
Highest quintile	27.2	27.5	24.1	26.0	26.8	−1.4	11.0	3.3	−4.5
Top 10 percent	28.8	28.6	24.5	26.5	27.7	−4.0	13.1	4.3	−8.0
Top 5 percent	30.6	29.6	24.6	26.7	28.3	−7.6	15.0	5.9	−12.8

[1] Projected.

Note.—Table reads for **boldface** figure that for the lowest 20 percent in income of the population in 1977, total Federal taxes were 9.3 percent of income.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 15.—AVERAGE ADJUSTED PRE-TAX FAMILY INCOME FOR ALL FAMILIES

[Income expressed as multiples of the poverty thresholds]

All families (by income group)	1977	1980	1985	1988	1992 [1]	Percentage change			
						1977–92	1985–92	1988–92	1977–88
Lowest quintile	**0.97**	0.93	0.87	0.88	0.87	−10.1	0.5	−0.9	−9.3
Second quintile	2.12	2.07	2.02	2.08	2.06	−3.1	1.8	−1.2	−2.0
Middle quintile	3.21	3.18	3.22	3.34	3.30	2.8	2.6	−1.1	3.9
Fourth quintile	4.53	4.56	4.75	4.97	4.91	8.4	3.5	−1.1	9.6
81 to 90 percent	6.16	6.24	6.71	7.02	6.95	12.7	3.5	−1.0	13.9
91 to 95 percent	7.92	8.05	8.85	9.27	9.19	16.0	3.8	−0.9	17.1
96 to 99 percent	11.36	11.71	13.22	14.58	14.60	28.5	10.4	0.1	28.3
Top 1 percent	33.81	36.81	50.16	66.04	72.03	113.0	43.6	9.1	95.3
Overall	4.00	4.03	4.31	4.63	4.65	16.1	7.9	0.5	15.6
Highest quintile	9.11	9.40	10.72	11.94	12.12	33.1	13.1	1.5	31.1
Top 10 percent	11.97	12.41	14.58	16.65	17.08	42.7	17.1	2.6	39.1
Top 5 percent	15.88	16.73	20.25	24.04	25.01	57.5	23.5	4.0	51.4

[1] Projected.

Note.—Table reads for **boldface** figure that for the lowest 20 percent in income of the population in 1977, the average family was at .97 percent of the poverty threshold.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 16.—AVERAGE ADJUSTED POST-TAX FAMILY INCOME FOR ALL FAMILIES

[Income expressed as multiples of the poverty thresholds]

All families (by income group)	1977	1980	1985	1988	1992 [1]	Percentage change 1977–92	1985–92	1988–92	1977–88
Lowest quintile	**0.89**	0.85	0.79	0.80	0.80	−10.1	1.3	0.0	−9.6
Second quintile	1.81	1.76	1.72	1.76	1.75	−3.3	1.7	−0.6	−2.5
Middle quintile	2.60	2.56	2.62	2.69	2.66	2.3	1.5	−1.1	3.6
Fourth quintile	3.54	3.51	3.72	3.86	3.83	8.2	3.0	−0.8	9.0
81 to 90 percent	4.67	4.65	5.13	5.29	5.23	12.0	1.9	−1.1	13.2
91 to 95 percent	5.91	5.91	6.69	6.84	6.78	14.7	1.3	−0.9	15.8
96 to 99 percent	8.29	8.43	9.99	10.70	10.66	28.6	6.7	−0.4	29.1
Top 1 percent	21.76	25.08	37.64	48.32	51.00	134.4	35.5	5.5	122.1
Overall	3.09	3.09	3.38	3.57	3.57	15.5	5.6	0.0	15.6
Highest quintile	6.61	6.80	8.12	8.83	8.87	34.2	9.2	0.5	33.6
Top 10 percent	8.50	8.85	10.99	12.22	12.36	45.4	12.5	1.1	43.8
Top 5 percent	11.00	11.75	15.25	17.61	17.97	63.4	17.8	2.0	60.1

[1] Projected.

Note.—Table reads for **boldface** figure that for the lowest 20 percent in income of the population in 1977, the average family was at .89 percent of the poverty threshold.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 17.—FEDERAL EFFECTIVE TAX RATES FOR DIFFERENT KINDS OF TAXES FOR ALL FAMILIES

All families (by income group)	1977	1980	1985	1988	1992 [1]	Percentage change			
						1977–92	1985–92	1988–92	1977–88
Individual income tax:									
Lowest quintile	−0.6	−0.5	−0.2	−1.7	−2.8	NA	NA	NA	NA
Second quintile	3.4	4.5	3.8	3.0	2.6	−22.1	−30.9	−10.9	−12.6
Middle quintile	6.9	7.9	6.7	6.4	6.3	−8.6	−6.6	−1.7	−7.0
Fourth quintile	9.6	11.0	9.3	8.9	8.7	−9.1	−5.6	−1.5	−7.7
81 to 90 percent	12.0	13.5	11.3	11.3	11.3	−6.2	−0.1	0.4	−6.5
91 to 95 percent	13.9	15.3	12.7	13.2	13.1	−5.9	2.9	−1.1	−4.9
96 to 99 percent	16.6	18.4	15.0	16.2	16.5	−0.6	9.9	1.8	−2.4
Top 1 percent	25.2	23.9	19.5	20.7	23.7	−6.0	21.3	14.1	−17.6
Overall	11.1	12.3	10.7	11.0	11.5	3.6	7.3	4.3	−0.7
Highest quintile	**16.1**	17.2	14.4	15.4	16.3	1.7	13.4	6.4	−4.5
Top 10 percent	18.1	19.0	15.8	17.1	18.4	1.2	16.0	7.7	−6.0
Top 5 percent	20.2	20.8	17.2	18.5	20.3	0.4	18.3	9.6	−8.4
Social insurance tax:									
Lowest quintile	5.1	5.2	6.7	7.1	7.3	42.5	9.9	3.2	38.1
Second quintile	7.5	7.8	9.1	9.5	9.7	28.3	6.5	1.4	26.5
Middle quintile	8.1	8.6	9.7	10.1	10.3	27.1	5.8	1.5	25.2
Fourth quintile	7.8	8.6	9.8	10.3	10.5	34.4	6.8	1.4	32.5
81 to 90 percent	7.4	8.3	9.6	10.2	10.4	40.3	8.5	1.8	37.8
91 to 95 percent	6.5	7.4	8.9	9.5	9.9	53.1	11.7	3.8	47.4
96 to 99 percent	4.4	5.2	6.4	6.8	7.4	67.7	17.0	9.9	52.6

Top 1 percent	1.3	1.5	1.7	1.4	1.7	37.6	2.1	19.3	15.3
Overall	6.5	7.2	8.2	8.4	8.6	30.9	4.9	2.2	28.1
Highest quintile	5.3	6.0	6.8	6.9	7.2	35.6	5.3	3.5	31.0
Top 10 percent	4.2	4.8	5.6	5.6	5.9	39.9	5.9	5.6	32.5
Top 5 percent	3.1	3.6	4.1	4.0	4.4	42.7	6.8	9.0	30.9
Corporate income tax:									
Lowest quintile	1.9	1.3	1.0	1.2	1.0	−45.5	5.6	−13.8	−36.8
Second quintile	2.7	2.0	1.3	1.7	1.5	−45.8	11.0	−13.9	−37.0
Middle quintile	3.0	2.2	1.5	2.0	1.7	−43.8	10.6	−13.5	−35.1
Fourth quintile	3.2	2.4	1.7	2.1	1.9	−41.3	11.3	−13.0	−32.6
81 to 90 percent	3.4	2.6	1.8	2.3	2.0	−41.6	10.5	−12.4	−33.4
91 to 95 percent	3.9	3.0	2.0	2.5	2.2	−43.5	9.8	−12.5	−35.5
96 to 99 percent	5.1	3.8	2.4	3.0	2.6	−49.1	8.8	−14.1	−40.7
Top 1 percent	8.8	6.1	3.4	4.4	3.6	−59.3	6.3	−18.4	−50.1
Overall	3.9	2.9	1.9	2.5	2.2	−43.9	11.9	−13.9	−35.0
Highest quintile	5.0	3.7	2.4	3.1	2.6	−47.2	11.4	−14.4	−38.3
Top 10 percent	5.7	4.2	2.6	3.4	2.9	−50.1	10.5	−15.2	−41.1
Top 5 percent	6.7	4.8	2.9	3.7	3.1	−53.2	9.1	−16.2	−44.2
Excise taxes:									
Lowest quintile	2.9	2.1	2.8	2.8	3.0	2.1	5.3	8.5	−5.9
Second quintile	1.8	1.3	1.5	1.7	1.8	1.9	19.8	10.9	−8.1
Middle quintile	1.5	1.1	1.2	1.3	1.4	−1.9	24.3	11.7	−12.1
Fourth quintile	1.3	0.9	0.9	1.0	1.2	−8.3	22.7	12.3	−18.3
81 to 90 percent	1.1	0.8	0.8	0.9	1.0	−11.9	29.7	13.2	−22.1
91 to 95 percent	1.0	0.7	0.7	0.8	0.9	−12.9	31.5	12.7	−22.7
96 to 99 percent	0.8	0.6	0.5	0.5	0.5	−32.5	6.4	9.8	−38.5

TABLE 17.—FEDERAL EFFECTIVE TAX RATES FOR DIFFERENT KINDS OF TAXES FOR ALL FAMILIES—Continued

All families (by income group)	1977	1980	1985	1988	1992 [1]	Percentage change			
						1977–92	1985–92	1988–92	1977–88
Top 1 percent	0.3	0.3	0.3	0.3	0.3	–3.4	6.0	5.8	–8.7
Overall	1.3	0.9	1.0	1.0	1.1	–13.6	14.2	10.2	–21.6
Highest quintile	0.9	0.6	0.6	0.6	0.7	–22.5	17.3	10.0	–29.6
Top 10 percent	0.7	0.5	0.5	0.5	0.5	–25.9	12.0	8.7	–31.9
Top 5 percent	0.6	0.4	0.4	0.4	0.4	–29.8	3.4	7.2	–34.5

[1] Projected.

Note.—Table reads for **boldface** figure that for the highest 20 percent in income of the population in 1977, individual income taxes were 16.1 percent of income.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 18.—CHANGES IN INDIVIDUAL INCOME TAX RATES AND SOCIAL INSURANCE WITH EITC COUNTED AS PART OF SOCIAL INSURANCE TAXES [1]

All families (by income group)	1977	1980	1985	1988	1992 [2]	Percentage change			
						1977–92	1985–92	1988–92	1977–88
Individual income tax:									
Lowest quintile	0.4	0.7	0.9	0.5	0.5	28.6	−48.6	−3.1	32.7
Second quintile	3.6	4.7	4.0	3.5	3.5	−1.9	−11.9	−0.8	−1.2
Middle quintile	6.9	8.0	6.8	6.5	6.4	−7.2	−5.1	−1.0	−6.3
Fourth quintile	9.6	11.0	9.3	8.9	8.8	−8.8	−5.6	−1.4	−7.5
81 to 90 percent	12.1	13.5	11.3	11.3	11.3	−6.1	0.0	0.4	−6.5
91 to 95 percent	13.9	15.3	12.7	13.2	13.1	−5.9	2.9	−1.0	−4.9
96 to 99 percent	16.6	18.4	15.0	16.2	16.5	−0.6	9.9	1.8	−2.3
Top 1 percent	25.2	23.9	19.5	20.7	23.7	−6.0	21.3	14.1	−17.6
Total	11.1	12.4	10.7	11.1	11.7	4.9	8.7	4.9	0.0
Highest quintile	16.1	17.2	14.4	15.4	16.4	1.7	13.4	6.5	−4.4
Top 10 percent	18.1	19.0	15.8	17.1	18.4	1.2	16.0	7.7	−6.0
Top 5 percent	20.2	20.8	17.2	18.5	20.3	0.4	18.3	9.6	−8.4
Social insurance:									
Lowest quintile	4.2	4.0	5.6	4.9	4.1	−1.6	−26.6	−15.9	17.0
Second quintile	7.4	7.6	8.9	9.0	8.8	19.8	−1.3	−1.8	22.0
Middle quintile	8.0	8.6	9.7	10.0	10.1	26.0	4.8	1.1	24.7
Fourth quintile	7.8	8.6	9.8	10.3	10.4	34.1	6.5	1.3	32.4
81 to 90 percent	7.4	8.3	9.6	10.2	10.4	40.2	8.4	1.8	37.8
91 to 95 percent	6.5	7.4	8.9	9.5	9.9	53.0	11.7	3.8	47.4
96 to 99 percent	4.4	5.2	6.4	6.8	7.4	67.7	16.9	9.9	52.5
Top 1 percent	1.3	1.5	1.7	1.4	1.7	37.5	2.0	19.3	15.3
Total	6.5	7.1	8.1	8.2	8.3	29.0	3.0	1.4	27.3
Highest quintile	5.3	6.0	6.8	6.9	7.2	35.5	5.3	3.5	31.0
Top 10 percent	4.2	4.8	5.6	5.6	5.9	39.9	5.9	5.6	32.5
Top 5 percent	3.1	3.6	4.1	4.0	4.4	42.7	6.8	9.0	30.9

---

[1] The EITC is counted as part of social insurance taxes instead of part of individual income taxes.

[2] Projected.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 19.—AVERAGE REAL PRETAX AND AFTER-TAX INCOME FOR ALL FAMILIES

All families (by income quintile group)	(In constant 1992 dollars)					Percentage change			
	1977	1980	1985	1988	1992 [1]	1977–92	1985–92	1988–92	1977–88
Average real pretax income:									
Lowest	9,368	8,791	8,198	8,167	8,132	−13.2	−0.8	−0.4	−12.8
Second	22,333	21,009	19,940	20,347	20,094	−10.0	0.8	−1.2	−8.9
Third	34,505	32,948	32,142	32,332	31,970	−7.3	−0.5	−1.1	−6.3
Fourth	46,772	45,827	46,444	48,420	47,692	2.0	2.7	−1.5	3.5
Highest	**87,268**	89,031	100,526	111,034	112,652	29.1	12.1	1.5	27.2
Overall	40,065	39,443	41,359	43,859	44,029	9.9	6.5	0.4	9.5
Average real after-tax income:									
Lowest	8,495	8,079	7,353	7,408	7.434	−12.5	0.4	−4.9	−12.8
Second	18,885	17,740	16,798	17,120	16,955	−10.2	−1	−6.1	−9.3
Third	27,788	26,417	25,988	25,937	25,670	−7.6	−1	−4.9	−6.7
Fourth	36,563	35,320	36,367	37,592	37,094	1.5	−1.3	−3.4	2.8
Highest	63,546	64,583	76,252	82,220	82,455	29.8	0.3	1.6	29.4
Overall	30,948	30,269	32,364	33,822	33,722	9.1	−0.1	−2.2	9.3
People (in millions): [2]									
Lowest	40.6	42	43.6	45.9	48	18.1	10.0	4.4	13.1
Second	42.9	45	47.2	48.6	50.9	18.6	7.9	4.7	13.3
Third	42.9	45	47.2	48.6	50.8	18.3	7.5	4.5	13.3
Fourth	42.9	45	47.2	48.6	50.8	18.6	7.7	4.7	13.3
Highest	42.9	45	47.2	48.6	50.8	18.5	7.6	4.6	13.3
Overall	214.4	224.9	236	242.9	254	18.5	7.6	4.6	13.3

[1] Projected.

[2] The lowest quintile does not include those people with negative incomes.

Note: Table reads for **boldface** figure that for the highest 20 percent in income of the population in 1977, average real family income (1992 dollars) was $87,268.

TABLE 20.—TOTAL FEDERAL EFFECTIVE TAX RATES BY FAMILY TYPE

[By quintile]

Family type (by income group)	1977	1980	1985	1988	1992	Percentage change		
						1977–92	1985–92	1988–92
For families with children:								
Lowest	**10.2**	9.3	11.9	9.3	7.7	−25	−36	−17
Second	17.3	17.9	18.4	18.0	17.6	2	−4	−2
Third	20.7	21.4	21.3	21.7	21.7	5	2	0
Fourth	22.5	23.9	23.2	23.6	23.7	5	2	1
Highest	26.8	27.1	24.2	25.9	27.5	3	13	6
Overall	22.2	23.0	22.2	22.9	23.5	6	6	3
For elderly families:								
Lowest	5.2	3.6	2.7	3.0	3.0	−43	9	−1
Second	6.8	5.5	4.0	5.1	4.9	−27	24	−3
Third	10.0	9.1	7.4	8.4	8.0	−19	9	−5
Fourth	14.0	13.6	11.5	13.8	12.9	−8	12	−7
Highest	24.1	25.2	21.2	23.2	23.3	−3	10	0
Overall	16.3	16.8	14.5	16.2	16.3	0	12	1
For nonelderly families without children:								
Lowest	12.1	10.9	13.7	14.8	15.0	24	9	2
Second	16.9	17.5	18.5	19.2	19.1	13	3	0
Third	20.9	21.2	21.4	22.4	22.4	7	5	0
Fourth	23.1	24.2	23.3	23.9	23.9	3	3	0
Highest	28.2	28.3	25.0	26.7	27.5	−2	10	3
Overall	25.5	25.8	23.9	25.1	25.6	1	7	2

Note: Table reads for **boldface** figure that for families with children in the lowest 20 percent in income of the total population in 1977, total Federal taxes were 10.2 percent of income.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 21.—SHARES OF TOTAL FEDERAL TAXES PAID BY ALL FAMILIES

[In percent]

All families (by income group)	1977	1980	1985	1988	1992 [1]
Lowest quintile	**2.0**	1.6	1.8	1.5	1.3
Second quintile	7.2	6.9	6.8	6.2	6.0
Middle quintile	13.4	13.2	13.0	12.5	12.1
Fourth quintile	21.6	22.1	22.0	20.8	20.0
81 to 90 percent	16.7	17.1	17.0	16.4	15.9
91 to 95 percent	11.3	11.7	11.7	11.6	11.3
96 to 99 percent	14.1	14.5	14.2	15.0	15.0
Top 1 percent	13.6	12.9	13.3	15.9	18.3
Overall	100.0	100.0	100.0	100.0	100.0
Highest quintile	55.7	56.1	56.1	58.9	60.5
Top 10 percent	39.0	39.0	39.2	42.5	44.6
Top 5 percent	27.7	27.3	27.5	30.9	33.3

[1] Projected.

Note.—Table reads for **boldface** figure that the lowest 20 percent in income of the population in 1977 bore the burden of 2.0 percent of total Federal taxes.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 22.—SHARES OF PRETAX INCOME FOR ALL FAMILIES

[In percent]

All families (by income group)	1977	1980	1985	1988	1992 [1]
Lowest quintile	**4.9**	4.5	3.8	3.7	3.6
Second quintile	10.6	10.3	9.4	9.0	8.9
Middle quintile	15.7	15.5	14.8	14.5	14.3
Fourth quintile	22.5	22.5	22.0	21.2	21.0
81 to 90 percent	15.8	15.7	15.7	15.2	15.0
91 to 95 percent	10.2	10.3	10.5	10.2	10.1
96 to 99 percent	11.9	12.0	12.7	12.9	12.9
Top 1 percent	8.7	9.4	11.6	13.5	14.6
Overall	100.0	100.0	100.0	100.0	100.0
Highest quintile	46.6	47.5	50.6	51.9	52.6
Top 10 percent	30.8	31.7	34.8	36.7	37.6
Top 5 percent	20.6	21.4	24.3	26.5	27.5

[1] Projected.

Note.—Table reads for **boldface** figure that the lowest 20 percent in income of the population in 1977 received 4.9 percent of total pretax income.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 23.—SHARES OF AFTER-TAX INCOME FOR ALL FAMILIES

[In percent]

All families (by income-group)	1977	1980	1985	1988	1992 [1]
Lowest quintile	**5.7**	5.4	4.4	4.3	4.3
Second quintile	11.6	11.4	10.1	9.8	9.8
Middle quintile	16.3	16.2	15.3	15.1	14.9
Fourth quintile	22.7	22.6	22.0	21.4	21.3
81 to 90 percent	15.6	15.3	15.4	14.9	14.7
91 to 95 percent	9.9	9.9	10.2	9.8	9.8
96 to 99 percent	11.3	11.3	12.3	12.3	12.3
Top 1 percent	7.3	8.4	11.2	12.8	13.4
Overall	100.0	100.0	100.0	100.0	100.0
Highest quintile	44.0	44.9	49.0	49.8	50.2
Top 10 percent	28.4	29.5	33.6	35.0	35.4
Top 5 percent	18.5	19.7	23.4	25.2	25.7

[1] Projected.

Note.—Table reads for **boldface** figure that the lowest 20 percent in income of the population in 1977 received 5.7 percent of total after-tax income.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 24.—SHARES OF TAX BURDENS FOR DIFFERENT KINDS OF TAXES FOR ALL FAMILIES

[By quintile, in percent]

All families (by income group)	1977	1980	1985	1988	1992 [1]
Individual income tax:					
Lowest quintile	−0.3	−0.2	−0.1	−0.6	−0.9
Second quintile	3.2	3.8	3.4	2.4	2.0
Middle quintile	9.8	10.0	9.3	8.5	7.8
Fourth quintile	19.5	20.0	19.1	17.1	16.0
81 to 90 percent	17.2	17.3	16.7	15.6	14.8
91 to 95 percent	12.8	12.8	12.5	12.3	11.5
96 to 99 percent	17.9	18.0	17.8	19.1	18.6
Top 1 percent	19.9	18.3	21.2	25.6	30.1
Overall	100.0	100.0	100.0	100.0	100.0
Highest quintile	67.8	66.4	68.2	72.6	75.0
Top 10 percent	50.5	49.1	51.6	57.0	60.2
Top 5 percent	37.7	36.3	39.1	44.7	48.6
Social insurance:					
Lowest quintile	3.8	3.3	3.1	3.1	3.1
Second quintile	12.2	11.3	10.5	10.2	10.0
Middle quintile	19.4	18.7	17.6	17.5	17.1
Fourth quintile	26.8	27.1	26.4	26.2	25.7
81 to 90 percent	17.8	18.2	18.4	18.5	18.2
91 to 95 percent	10.1	10.6	11.4	11.6	11.7
96 to 99 percent	8.1	8.7	9.9	10.4	11.2
Top 1 percent	1.7	2.0	2.4	2.3	2.9
Overall	100.0	100.0	100.0	100.0	100.0
Highest quintile	37.7	39.6	42.1	42.9	44.0
Top 10 percent	19.8	21.3	23.7	24.4	25.8
Top 5 percent	9.7	10.7	12.3	12.8	14.1
Corporate:					
Lowest quintile	2.3	2.1	1.9	1.7	1.7
Second quintile	7.4	6.9	6.4	6.1	6.0
Middle quintile	12.2	11.8	11.7	11.3	11.1
Fourth quintile	18.4	18.8	18.9	18.0	18.0
81 to 90 percent	13.9	14.2	14.6	13.7	13.8
91 to 95 percent	10.1	10.5	10.7	10.1	10.1
96 to 99 percent	15.7	15.7	15.7	15.6	15.5
Top 1 percent	19.7	19.8	20.0	23.4	23.8
Overall	100.0	100.0	100.0	100.0	100.0
Highest quintile	59.5	60.1	61.0	62.8	63.1
Top 10 percent	45.5	45.9	46.3	49.0	49.4
Top 5 percent	35.4	35.4	35.7	39.0	39.3

TABLE 24.—SHARES OF TAX BURDENS FOR DIFFERENT KINDS OF TAXES FOR ALL FAMILIES—Continued

[By quintile, in percent]

All families (by income group)	1977	1980	1985	1988	1992[1]
Excise:					
Lowest quintile	11.4	10.3	11.4	10.3	9.9
Second quintile	15.2	15.2	15.2	15.2	15.1
Middle quintile	18.2	18.3	17.9	18.9	18.8
Fourth quintile	22.5	22.8	21.8	22.2	22.3
81 to 90 percent	14.2	14.1	12.7	13.5	13.7
91 to 95 percent	8.1	8.3	7.3	8.0	8.1
96 to 99 percent	7.6	7.8	6.8	6.5	6.5
Top 1 percent	2.3	2.8	3.7	4.1	4.2
Overall	100.0	100.0	100.0	100.0	100.0
Highest quintile	32.2	33.0	30.5	32.2	32.6
Top 10 percent	18.0	18.9	17.8	18.6	18.8
Top 5 percent	9.9	10.6	10.5	10.6	10.7
Total Federal taxes:					
Lowest quintile	2.0	1.6	1.8	1.5	1.3
Second quintile	7.2	6.9	6.8	6.2	6.0
Middle quintile	13.4	13.2	13.0	12.5	12.1
Fourth quintile	21.6	22.1	22.0	20.8	20.0
81 to 90 percent	16.7	17.1	17.0	16.4	15.9
91 to 95 percent	11.3	11.7	11.7	11.6	11.3
96 to 99 percent	14.1	14.5	14.2	15.0	15.0
Top 1 percent	13.6	12.9	13.3	15.9	18.3
Overall	100.0	100.0	100.0	100.0	100.0
Highest quintile	55.7	56.1	56.1	58.9	60.5
Top 10 percent	39.0	39.0	39.2	42.5	44.6
Top 5 percent	27.7	27.3	27.5	30.9	33.3

[1] Projected.

Note.—Table reads for **boldface** figure that the highest 20 percent in income of the population in 1977 paid 67.8 percent of total individual income taxes.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 25.—TOTAL 1992 PRETAX INCOME DISTRIBUTED ACCORDING TO 1992 INCOME SHARES AND 1977, 1980, 1985 AND 1988 SHARES

[In billions of dollars]

	Total 1992 pretax income					Change in 1992 income relative to			
	1992 shares	1977 shares	1980 shares	1985 shares	1988 shares	1977	1980	1985	1988
Lowest quintile	168.1	**227.4**	209.2	177.8	171.6	−59.3	−41.0	−9.7	−3.4
Second quintile	413.8	492.8	480.8	438.4	419.4	−79.0	−67.0	−24.6	−5.6
Middle quintile	664.4	729.8	722.5	689.0	675.5	−65.3	−56.0	−24.5	−11.0
Fourth quintile	977.1	1,046.0	1,045.5	1,024.0	988.4	−69.0	−62.4	−46.9	−11.3
81 to 90 percent	698.6	735.7	732.2	732.4	707.8	−37.2	−33.6	−33.9	−9.3
91 to 95 percent	470.9	474.5	478.8	488.9	475.8	−3.6	−7.9	−18.0	−4.9
96 to 99 percent	599.9	553.8	559.7	590.8	601.4	−46.1	−40.2	9.2	−1.5
Top 1 percent	677.3	406.3	436.3	540.9	630.3	271.4	239.4	136.8	47.4
Total	4,653.3	4,653.3	4,653.3	4,653.3	4,653.3	0.0	0.0	0.0	0.0
Highest quintile	2,447.1	2,170.3	2,209.1	2,352.9	2,415.3	276.8	238.0	94.2	31.8
Top 10 percent	1,748.6	1,434.6	1,476.9	1,620.5	1,707.5	313.9	271.6	128.0	41.1
Top 5 percent	1,277.6	960.1	988.1	1,131.7	1,231.7	317.5	279.5	146.0	46.0

Note: Table reads for **boldface** figure that the lowest 20 percent in income of the population in 1977 would have received $227.4 billion of pretax income if 1992 income had been distributed as it was in 1977.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 26.—TOTAL 1992 FEDERAL TAXES DISTRIBUTED ACCORDING TO 1992 EFFECTIVE TAX RATES AND 1977, 1980, 1985, AND 1988 EFFECTIVE TAX RATES, ADJUSTED TO 1992 LEVELS

[In billions of dollars]

	Total 1992 Federal taxes					Change in 1992 taxes relative to			
	1992 effective tax rates	1977 effective tax rates	1980 effective tax rates	1985 effective tax rates	1988 effective tax rates	1977	1980	1985	1988
Lowest quintile	14.4	**14.2**	13.2	17.3	15.8	0.2	1.2	−2.9	−1.3
Second quintile	64.6	56.2	58.7	66.0	66.4	8.5	5.9	−1.3	−1.8
Middle quintile	130.9	117.5	121.0	127.9	133.0	13.4	9.9	3.0	−2.1
Fourth quintile	217.1	200.5	205.4	211.1	2319.3	16.6	11.7	6.0	−2.2
81 to 90 percent	172.3	158.9	163.1	164.9	173.3	13.4	9.2	7.4	−1.0
91 to 95 percent	122.6	113.7	117.3	117.7	123.8	9.0	5.4	5.0	−1.1
96 to 99 percent	162.6	158.5	161.7	156.5	161.5	4.1	0.9	6.1	1.0
Top 1 percent	198.5	263.7	242.9	221.8	190.0	−65.3	−44.4	−23.3	8.5
Total	1,084.1	1,084.1	1,084.1	1,084.1	1,084.1	0.0	0.0	0.0	0.0
Highest quintile	656.0	694.7	685.0	660.8	648.6	−38.8	−29.0	−4.8	7.4
Top 10 percent	483.6	535.9	521.8	495.9	475.2	−52.2	−38.2	−12.2	8.4
Top 5 percent	361.0	422.2	404.5	378.2	351.5	−61.2	−43.5	−17.2	9.5

Note: Rates are adjusted to keep total taxes the same as under current law.

Note: Table reads for **boldface** figure that the lowest 20 percent in income of the population in 1977 would have paid 14.2 billion of taxes if the 1977 effective tax rate had been applied to 1992 income.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 27.—TOTAL 1992 AFTER-TAX INCOME DISTRIBUTED ACCORDING TO 1992 INCOMES SHARES AND 1977, 1980, 1985 AND 1988 SHARES

[In billions of dollars]

	Total 1992 after-tax income					Change in 1992 income relative to			
	1992	1977	1980	1985	1988	1977	1980	1985	1988
Lowest quintile	153.7	**204.8**	192.1	156.4	154.8	−51.0	−38.4	−2.7	−1.1
Second quintile	349.2	413.8	405.8	362.0	351.0	−64.6	−56.6	−12.9	−1.8
Middle quintile	533.5	583.6	579.0	546.1	539.0	−50.0	−45.5	−12.5	−5.4
Fourth quintile	760.0	812.0	805.4	786.0	763.3	−52.0	−45.5	−26.0	−3.3
81 to 90 percent	526.3	555.3	547.0	549.6	530.8	−29.0	−20.8	−23.3	−4.5
91 to 95 percent	348.3	352.3	352.5	363.1	350.0	−4.0	−4.2	−14.8	−1.8
96 to 99 percent	437.4	401.6	403.1	438.5	439.6	35.8	34.3	−1.1	−2.2
Top 1 percent	479.2	260.2	299.0	398.4	458.5	219.1	180.2	80.9	20.8
Total	3,569.2	3,569.2	3,569.2	3,569.2	3,569.2	0.0	0.0	0.0	0.0
Highest quintile	1,791.2	1,569.3	1,601.7	1,749.5	1,778.9	221.9	189.5	41.7	12.2
Top 10 percent	1,264.9	1,014.0	1,054.6	1,199.9	1,248.1	250.9	210.3	65.0	16.8
Top 5 percent	916.6	661.7	702.1	836.8	898.1	254.9	214.5	79.8	18.6

Note: Table reads for **boldface** figure that the lowest 20 percent in income of the population in 1977 would have received $204.8 billion of after-tax income if 1992 income had been distributed as it was in 1977.

Source: Congressional Budget Office (CBO) tax simulation model.

CHART 1. 1977 TO 1992 PERCENTAGE CHANGE IN REAL INCOME AND FEDERAL TAX RATES OF THE POPULATION RANKED BY INCOME

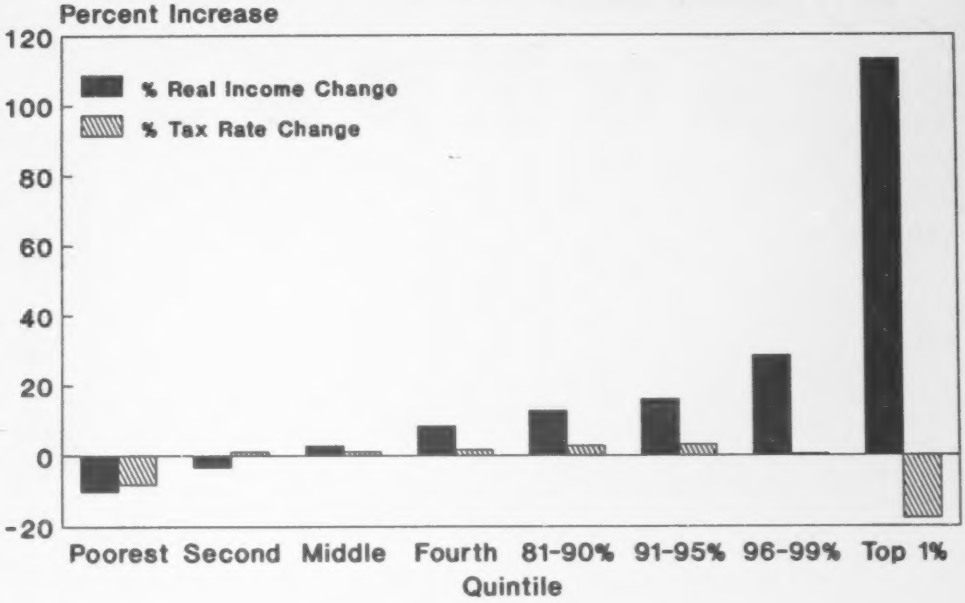


CHART 2. 1977 TO 1992 COMPARISON OF SHARES AND CHANGES IN SHARES OF AFTER-TAX INCOME FOR ALL FAMILIES

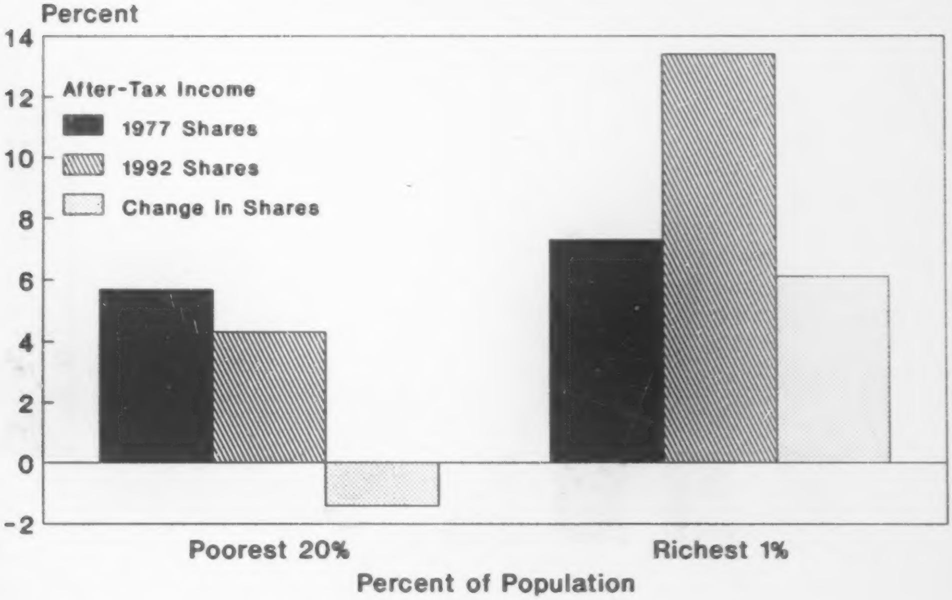


CHART 3. DIFFERENCE IN 1992 TOTAL FEDERAL TAXES ATTRIBUTABLE TO CHANGES IN EFFECTIVE TAX RATES BETWEEN 1977 AND 1992

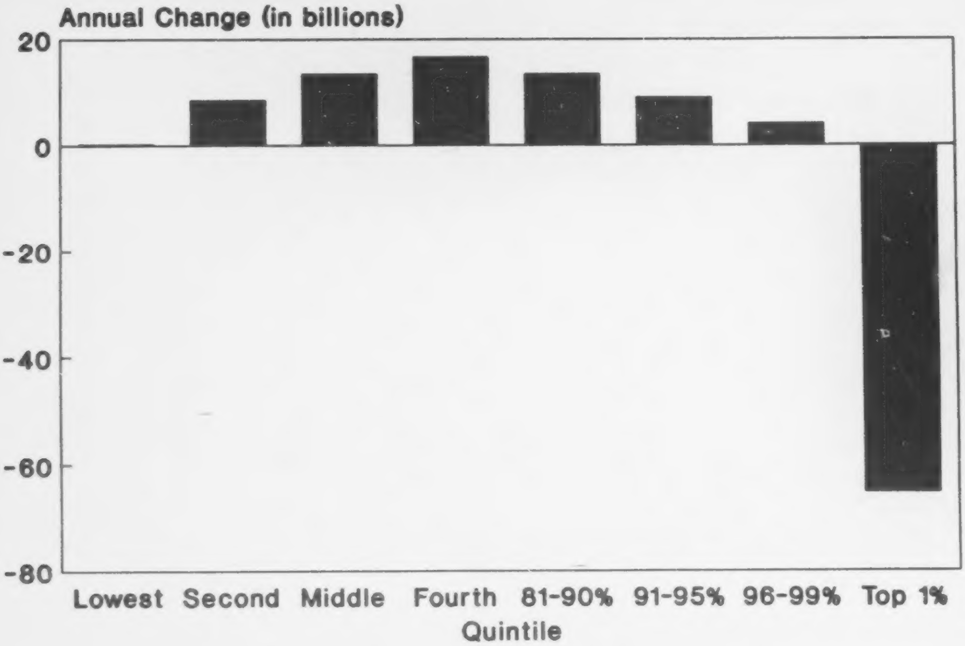


CHART 4. DIFFERENCE IN 1992 PRETAX INCOME ATTRIBUTABLE TO SHIFTS IN INCOME SHARES BETWEEN 1977 AND 1992

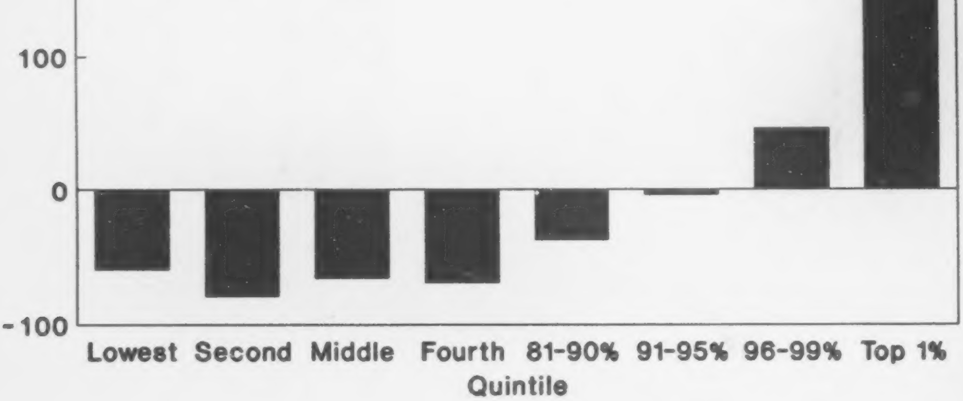
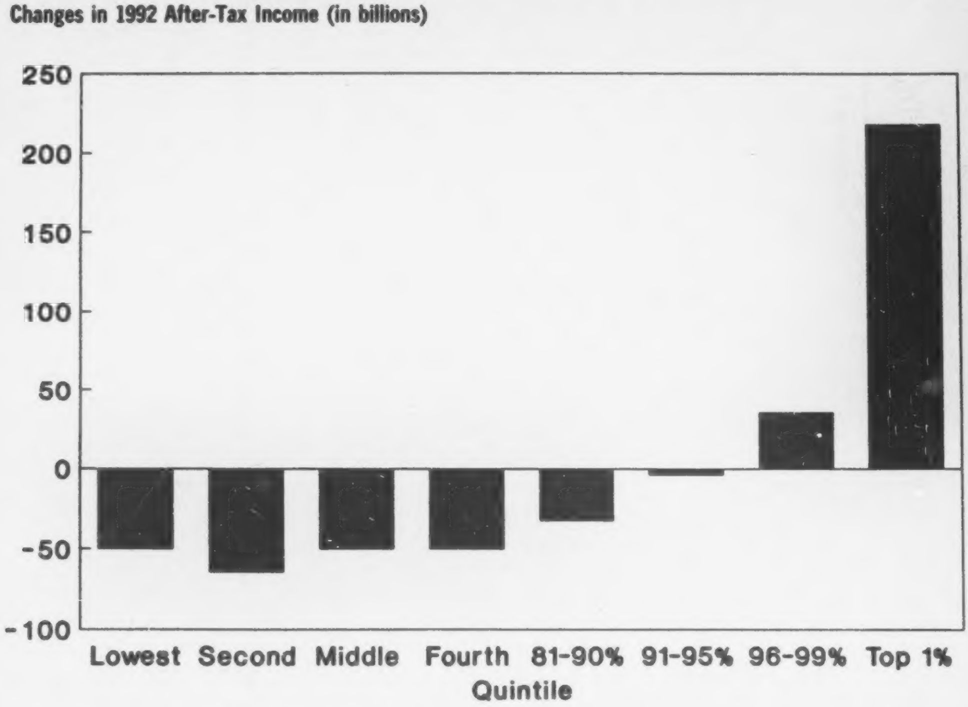


CHART 5. DIFFERENCE IN 1992 AFTER-TAX INCOME ATTRIBUTABLE TO SHIFTS IN INCOME SHARES BETWEEN 1977 AND 1992



Source: CBO Tax Simulation Model

TABLE 28.—CHANGES IN FEDERAL EFFECTIVE TAX RATES HOLDING INCOME AND DEMOGRAPHICS CONSTANT AT 1992 LEVELS

All families (by income group)	1977	1980	1985	1988	1992 [1]	Percentage change			
						1977–92	1985–92	1988–92	1977–88
Lowest quintile	**8.1**	8.2	10.1	9.0	8.6	6	−15	−5	11
Second quintile	13.0	14.8	15.6	15.4	15.6	20	0	1	18
Middle quintile	17.0	19.0	18.8	19.2	19.7	16	5	2	13
Fourth quintile	19.7	22.0	21.2	21.6	22.2	13	5	3	9
81 to 90 percent	21.8	24.4	23.1	23.9	24.7	13	7	3	9
91 to 95 percent	23.2	26.0	24.5	25.3	26.0	12.	6	3	9
96 to 99 percent	25.4	28.1	25.5	25.9	27.1	7	6	5	2
Top 1 percent	37.4	37.4	32.0	26.9	29.3	−22	−9	9	−28
Overall	22.4	24.3	22.8	22.4	23.3	4	2	4	0
Highest quintile	27.3	29.2	26.4	25.5	26.8	−2	1	5	−7
Top 10 percent	29.4	31.2	27.8	26.1	27.7	−6	0	6	−11
Top 5 percent	31.7	33.1	29.0	26.4	28.3	−11	−3	7	−17

[1] Projected.

Note: Table reads for **boldface** figure that for the lowest 20 percent in income of the population in 1992, total Federal taxes would be 8.1 percent of 1992 income under the 1977 Federal tax system.

Source: Congressional Budget Office (CBO) tax simulation model.

TABLE 29.—COMPARISON OF CHANGES IN FEDERAL EFFECTIVE TAX RATES AND FEDERAL TAX POLICY HOLDING INCOME AND DEMOGRAPHICS CONSTANT AT 1992 LEVELS FOR THE MIDDLE QUINTILE AND THE TOP 1 PERCENT

	1977	1980	1985	1988	1992 [1]	Percentage change			
						1977–92	1985–92	1988–92	1977–88
			Actual						
Top 1 percent:									
Individual income tax	**25.2**	23.9	19.5	20.7	23.7	−6	21	14	−18
Social insurance	1.3	1.5	1.7	1.4	1.7	38	2	19	15
Corporate income tax	8.8	6.1	3.4	4.4	3.6	−59	6	−18	−50
Excise tax	0.3	0.3	0.3	0.3	0.3	−3	6	6	−9
Total	35.6	31.7	24.9	26.9	29.3	−18	18	9	−24
			Holding Income and Demographics Constant						
Individual income tax	**32.4**	32.2	27.9	22.0	23.7	−27	−15	8	−32
Social insurance	0.8	1.0	1.3	1.3	1.7	125	34	29	75
Corporate income tax	3.9	4.0	2.5	3.4	3.6	−8	42	6	−13
Excise tax	0.3	0.2	0.3	0.3	0.3	2	4	15	−12
Total	37.4	37.4	32.0	26.9	29.3	−22	−9	9	−28

TABLE 29.—COMPARISON OF CHANGES IN FEDERAL EFFECTIVE TAX RATES AND FEDERAL TAX POLICY HOLDING INCOME AND DEMOGRAPHICS CONSTANT AT 1992 LEVELS FOR THE MIDDLE QUINTILE AND THE TOP 1 PERCENT—Continued

	1977	1980	1985	1988	1992 [1]	Percentage change			
						1977–92	1985–92	1988–92	1977–88
			Actual						
Middle quintile:									
Individual income tax	6.9	7.9	6.7	6.4	6.3	−9	−7	−2	−7
Social insurance	8.1	8.6	9.7	10.1	10.3	27	6	2	25
Corporate income tax	3.0	2.2	1.5	2.0	1.7	−44	11	−14	−35
Excise tax	1.5	1.1	1.2	1.3	1.4	−2	24	12	−12
Total	19.5	19.8	19.1	19.8	19.7	1	3	0	2
			Holding Income and Demographics Constant						
Individual income tax	5.9	7.7	6.7	6.3	6.3	6	−6	0	6
Social insurance	7.8	8.3	9.6	10.1	10.3	32	7	2	30
Corporate income tax	1.8	1.9	1.2	1.6	1.7	−8	42	6	−13
Excise tax	1.4	1.1	1.4	1.2	1.4	2	3	15	−11
Total	17.0	19.0	18.8	19.2	19.7	16	5	2	13

[1] Projected.

Note: Table reads for **boldface** figure in row 1 that for the top 1 percent in income of the population in 1977, total Federal individual income taxes would have been 25.2 percent of income.

Table reads for second **boldface** figure that for the top 1 percent in income of the population in 1992, total Federal individual income taxes were 32.4 percent of 1992 income under the 1977 Federal tax system.

Source: CBO Tax Model.

TABLE 30.—COMPARISON OF FEDERAL EFFECTIVE TAX RATES BY TYPE OF TAX FOR DIFFERENT FAMILY TYPES IN 1992 [1]

	Nonelderly without children	Elderly	Families with children	All families
Individual Income Tax				
Quintile:				
Lowest	0.6	0.0	−5.7	−2.8
Second	4.5	0.5	2.4	2.6
Third	7.5	2.6	6.7	6.3
Fourth	9.4	6.2	8.9	8.7
Highest	15.9	15.9	17.3	16.3
Overall	12.9	9.8	10.5	11.5
Social Insurance				
Quintile:				
Lowest	8.8	0.4	9.5	7.3
Second	10.9	1.3	12.0	9.7
Third	11.6	1.8	12.2	10.3
Fourth	11.5	2.8	12.0	10.5
Highest	8.5	2.5	7.3	7.2
Overall	9.6	2.2	10.1	8.6
Corporate Income Taxes				
Quintile:				
Lowest	1.2	0.5	1.1	1.0
Second	1.5	1.3	1.5	1.5
Third	1.6	2.2	1.6	1.7
Fourth	1.7	2.8	1.7	1.9
Highest	2.3	4.3	2.2	2.6
Overall	2.1	3.2	1.9	2.2
Excise Taxes				
Quintile:				
Lowest	4.3	2.1	2.7	3.0
Second	2.2	1.8	1.7	1.8
Third	1.6	1.4	1.3	1.4
Fourth	1.3	1.1	1.1	1.2
Highest	0.7	0.6	0.6	0.7
Overall	1.1	1.0	1.1	1.1
All Federal Taxes				
Quintile:				
Lowest	15.0	3.0	7.7	8.6
Second	19.1	4.9	17.6	15.6
Third	22.4	8.0	21.7	19.7
Fourth	23.9	12.9	23.7	22.2
Highest	27.5	23.3	27.5	26.8
Overall	25.6	16.3	23.5	23.3
Average Pretax Income				
Quintile:				
Lowest	5,008	6,206	8,716	6,780
Second	12,957	13,084	22,497	16,752

TABLE 30.—COMPARISON OF FEDERAL EFFECTIVE TAX RATES BY TYPE OF TAX FOR DIFFERENT FAMILY TYPES IN 1992 [1]—Continued

	Nonelderly without children	Elderly	Families with children	All families
Third	21,196	21,869	35,763	26,653
Fourth	33,446	33,712	51,751	39,760
Highest	83,716	91,240	122,685	93,916
Overall	36,534	29,684	41,033	36,707
	Average After Tax Income			
Quintile:				
Lowest	4,256	6,023	8,049	6,198
Second	10,478	12,439	18,537	14,135
Third	16,458	20,110	27,992	21,401
Fourth	25,452	29,376	39,482	30,925
Highest	60,712	70,002	88,980	68,742
Overall	27,173	24,856	31,376	28,155
	Average Adjusted Family Income			
Quintile:				
Lowest	0.84	1.04	0.80	0.87
Second	2.07	2.03	2.06	2.06
Third	3.31	3.30	3.30	13.30
Fourth	4.94	4.89	4.88	4.91
Highest	12.00	13.18	11.67	12.12
Overall	5.37	4.38	3.85	4.65
	People (In millions)			
Quintile:				
Lowest	9.2	6.3	32.4	48.0
Second	10.7	7.8	32.3	50.9
Third	13.9	7.0	29.8	50.8
Fourth	17.5	6.5	26.9	50.8
Highest	25.6	6.7	18.5	50.8
Overall	78.2	34.5	141.3	254.0

---

[1] Projected.

Source: Congressional Budget Office (CBO) Tax Simulation Model.

TABLE 31.—FEDERAL EFFECTIVE TAX RATES BY FAMILY TYPE BY POPULATION QUINTILE HOLDING INCOME AND DEMOGRAPHICS CONSTANT

	1977	1980	1985	1988	1992	Percentage change		
						1977–92	1985–92	1988–92
Families With Children								
Quintile:								
Lowest	**8.1**	8.4	11.0	9.0	7.7	−6	−30	−15
Second	14.9	17.3	18.2	17.6	17.6	18	−3	0
Third	18.9	21.4	21.1	21.2	21.7	15	3	2
Fourth	21.0	23.7	22.9	23.0	23.7	13	4	3
Highest	28.3	30.4	26.6	25.5	27.5	−3	3	8
Overall	22.4	24.7	23.1	22.5	23.5	5	2	5
Families With Aged Head								
Quintile:								
Lowest	2.8	2.4	2.8	2.7	3.0	4	7	10
Second	4.3	4.2	4.3	4.5	4.9	16	15	9
Third	6.2	7.3	7.0	7.7	8.0	30	15	4
Fourth	10.2	11.9	10.8	12.1	12.9	26	19	6
Highest	22.0	23.4	20.6	21.4	23.3	6	13	9
Overall	14.8	16.0	14.3	15.0	16.3	10	14	8
Other Families (Nonelderly Without Children)								
Quintile:								
Lowest	12.4	12.5	14.5	14.3	15.0	21	4	5
Second	15.4	17.3	18.4	18.8	19.1	24	4	2
Third	19.3	21.2	21.3	21.9	22.4	16	5	2
Fourth	21.6	23.6	22.9	23.3	23.9	11	4	2
Highest	28.3	30.3	28.1	26.7	27.5	−3	−2	3
Overall	25.1	27.0	25.7	24.9	25.6	2	0	3
All Families								
Quintile:								
Lowest	8.1	8.2	10.1	9.0	8.6	6	−15	−5
Second	13.0	14.8	15.6	15.4	15.6	20	0	1
Third	17.0	19.0	18.8	19.2	19.7	16	5	2
Fourth	19.7	22.0	21.2	21.6	22.2	13	5	3
Highest	27.3	29.2	26.4	25.5	26.8	−2	1	5
Overall	22.4	24.3	22.8	22.4	23.3	4	2	4

---

[1] Projected.

Note: Table reads for **boldface** figure that for families with children in the lowest 20 percent in income of the population in 1992, total Federal taxes were 8.1 percent of 1992 income under the 1977 Federal tax system.

Source: Congressional Budget Office (CBO) Tax Simulation Model.

TABLE 32.—INDIVIDUAL INCOME TAXES AND PAYROLL TAXES BY INCOME QUINTILE

	Effective tax rates			Percentage of families paying some taxes who pay larger Social Security taxes than income taxes	
	All Federal taxes	Individual income taxes	Social insurance payroll taxes	Employee share only	Employee and employer share
1992—All Families					
Quintile:					
Lowest	7.9	−2.7	7.3	96.6	97.2
Second	15.1	2.6	9.7	73.6	89.5
Middle	19.2	6.3	10.3	29.8	78.0
Fourth	21.8	8.7	10.5	10.8	71.4
Highest	26.6	16.3	7.2	3.1	33.6
All families	23.0	11.5	8.6	36.0	70.5
Families Paying Social Security Taxes					
Quintile:					
Lowest	11.0	−4.3	11.6	98.3	98.9
Second	17.8	3.1	11.9	78.4	95.4
Middle	21.3	6.8	11.9	34.3	90.0
Fourth	23.1	9.0	11.6	12.2	81.1
Highest	27.3	16.6	7.8	3.4	37.3
All families	24.1	12.0	9.6	39.6	77.8
1977—All Families					
Quintile:					
Lowest	9.3	−0.6	5.1	97.8	98.7
Second	15.4	3.4	7.5	62.0	92.0
Middle	19.5	6.9	8.1	16.9	71.4
Fourth	21.6	9.6	7.8	5.2	33.9
Highest	27.2	16.1	5.3	1.3	6.1
All families	22.8	11.1	6.5	28.9	53.5
Families Paying Social Security Taxes					
Quintile:					
Lowest	12.7	−1.0	8.7	98.9	99.8
Second	17.4	3.9	9.1	64.8	96.3
Middle	20.6	7.3	9.0	18.4	78.0
Fourth	22.6	9.9	8.5	5.8	37.6
Highest	27.6	16.3	5.8	1.4	6.8
All families	23.9	11.6	7.4	31.2	57.8

Source: Congressional Budget Office tax simulation models.

TABLE 33.—COMPARISON OF INCOME TAXES AND PAYROLL TAXES BY LEVEL OF FAMILY INCOME, 1992

[Number of families including single individuals, in thousands]

Family income (in thousands)	All	No taxes	Income tax only	Payroll tax only	Employer and employee		Employee only	
					Payroll tax > income tax	Payroll tax ≦ income tax	Payroll tax > income tax	Payroll tax ≦ income tax
All Families								
Less than $10	18,168	9,447	115	3,871	4,543	108	4,464	188
$10 to $20	20,264	4,343	1,346	1,348	12,733	475	5,243	4,964
$20 to $30	17,873	1,143	2,267	441	12,705	1,306	6,506	7,505
$30 to $40	13,351	165	1,795	83	9,206	2,141	3,562	7,785
$40 to $50	10,217	29	1,142	19	6,808	2,217	2,023	7,002
$50 to $75	15,086	16	1,076	25	9,393	4,574	1,573	12,395
$75 to $100	5,414	9	326	3	2,068	3,006	226	4,849
$100 or more	2,235	9	165	0	383	1,688	41	2,029
	3,077	0	201	0	161	2,715	47	2,828
All incomes	105,686	15,151	8,383	5,792	57,999	18,231	26,684	49,545
Families With Children								
Less than $10,000	4,928	2,010	19	333	2,500	30	2,488	42
$10,000 to $20,000	5,551	445	55	136	4,875	32	4,815	92
$20,000 to $30,000	5,721	91	90	73	5,218	245	4,518	945
$30,000 to $40,000	4,927	22	73	12	4,407	411	2,659	2,158
$40,000 to $50,000	4,191	3	51	1	3,725	409	1,467	2,667
$50,000 to $75,000	6,857	5	81	8	5,554	1,210	1,179	5,585
$75,000 to $100,000	2,274	0	15	0	1,161	1,097	157	2,102
$100,000 or more	826	0	3	0	189	634	21	803

TABLE 33.—COMPARISON OF INCOME TAXES AND PAYROLL TAXES BY LEVEL OF FAMILY INCOME, 1992—Continued

[Number of families including single individuals, in thousands]

Family income (in thousands)	All	No taxes	Income tax only	Payroll tax only	Employer and employee		Employee only	
					Payroll tax > income tax	Payroll tax ≦ income tax	Payroll tax > income tax	Payroll tax ≦ income tax
	1,127	0	2	0	62	1,062	12	1,111
All incomes	36,401	2,576	388	563	27,692	5,132	17,319	15,505
	Elderly childless units							
Less than $10,000	4,653	4,406	3	231	10	0	10	0
$10,000 to $20,000	5,350	3,367	906	601	410	61	332	139
$20,000 to $30,000	3,854	933	1,708	271	594	345	356	583
$30,000 to $40,000	2,433	118	1,365	41	474	433	148	758
$40,000 to $50,000	1,700	12	926	2	330	429	69	690
$50,000 to $75,000	1,696	7	771	9	255	651	31	875
$75,000 to $100,000	734	8	284	0	66	376	9	433
$100,000 or more	330	0	137	0	11	181	0	192
	495	0	175	0	6	314	0	320
All incomes	21,264	8,852	6,276	1,155	2,156	2,790	95	3,989
	Other families							
Less than $10,000	8,587	3,031	94	3,308	2,033	77	1,965	145
$10,000 to $20,000	9,363	531	384	610	7,448	381	3,096	4,753
$20,000 to $30,000	8,298	118	468	97	6,893	716	1,631	5,978
$30,000 to $40,000	5,991	25	308	30	4,326	1,297	754	4,868

$40,000 to $50,000	4,326	14	165	16	2,753	1,378	486	3,645
$50,000 to $75,000	6,533	4	224	8	3,584	2,713	362	5,935
$75,000 to $100,000	2,406	9	27	3	840	1,535	60	2,314
$100,000 or more	1,080	0	25	0	183	873	20	1,035
	1,455	0	24	8	92	1,339	33	1,398
All incomes	46,041	3,723	1,719	4,073	28,152	18,309	8,409	30,051

Source: CBO tax model.

TABLE 34.—MAXIMUM INCOME IN INCOME GROUPS BY FAMILY SIZE, 1992, 1988, 1985, 1980, AND 1977

	Maximum AFI	Family size				
		1	2	3	4	6
		Poverty Thresholds (in 1991 dollars)				
Amount		6,415	8,208	10,047	12,883	17,199
		Maximum Income (in 1991 dollars)				
		1992				
All families (by income group):						
Lowest	1.47	9,423	12,058	14,759	18,925	25,265
Second	2.67	17,101	26,786	26,786	34,346	45,851
Middle	3.99	25,613	32,776	40,118	51,441	68,674
Fourth	6.03	38,667	49,481	60,564	77,658	103,673
81 to 90 percent	8.10	51,983	66,521	81,422	104,403	139,377
91 to 95 percent	10.65	68,314	87,420	107,002	137,203	183,164
96 to 99 percent	26.35	169,022	216,293	264,742	339,464	453,181
		1988				
All families (by income group):						
Lowest	1.48	9,519	12,181	14,910	19,118	25,523
Second	2.69	17,287	22,122	27,077	34,719	46,350
Middle	4.04	25,915	33,162	40,590	52,047	69,482
Fourth	6.10	39,103	50,039	61,247	78,534	104,842
81 to 90 percent	8.19	52,535	67,227	82,286	105,511	140,856
91 to 95 percent	10.72	68,763	87,995	107,705	138,104	184,368
96 to 99 percent	25.21	161,710	206,935	253,288	324,777	433,574
		1985				
All families (by income group):						
Lowest	1.44	9,269	11,861	14,518	18,616	24,852
Second	2.61	16,748	21,432	26,233	33,637	44,905
Middle	3.87	24,856	31,808	38,933	49,921	66,644
Fourth	5.81	37,300	47,732	58,424	74,914	100,009
81 to 90 percent	7.83	50,206	64,247	78,639	100,834	134,613
91 to 95 percent	10.27	65,877	84,301	103,184	132,307	176,629
96 to 99 percent	20.83	133,614	170,982	209,281	268,350	358,245
		1980				
All families (by income group):						
Lowest	1.50	9,654	12,354	15,121	19,389	25,884
Second	2.64	16,921	21,654	26,504	33,985	45,370
Middle	3.77	24,189	30,954	37,888	48,581	64,856
Fourth	5.49	35,190	45,032	55,118	70,675	94,351
81 to 90 percent	7.22	46,313	59,265	72,540	93,014	124,173
91 to 95 percent	9.17	58,795	75,239	92,092	118,084	157,642

TABLE 34.—MAXIMUM INCOME IN INCOME GROUPS BY FAMILY SIZE, 1992, 1988, 1985, 1980, AND 1977—Continued

	Maximum AFI	Family size				
		1	2	3	4	6
96 to 99 percent.......	17.85	114,499	146,521	179,341	229,959	306,993
		1977				
All families (by income group):						
Lowest	1.57	10,090	12,912	15,804	20,265	27,053
Second	2.67	17,120	21,908	26,816	34,384	45,903
Middle........................	3.78	24,228	31,003	37,948	48,659	64,959
Fourth	5.44	34,876	44,629	54,626	70,044	93,508
81 to 90 percent.......	7.09	45,498	58,223	71,264	91,378	121,989
91 to 95 percent.......	9.03	57,904	74,098	90,695	116,294	155,251
96 to 99 percent.......	16.99	108,982	139,462	170,701	218,880	292,203

Note: Table reads for **boldface** figure that the highest income in the 96 to 99 percent income group for a one person family in 1992 (1991 dollars) is $169,022. In other words, a single individual with an income greater than $169,022 is in the top 1 percent of the income distribution.

Source: CBO tax simulation model.

APPENDIX K. STATISTICS ON THE WEALTH STATUS OF HOUSEHOLDS [1]

Estimates of personal wealth holdings are generally recognized as being difficult to obtain. Problems of both defining and measuring wealth, as well as problems of assuring that the very wealthiest are adequately represented in the data collected, must be addressed in order to obtain reasonable and consistent estimates.

Estimates of wealth generally include financial assets (such as stocks, bonds, business holdings, and savings accounts) and real estate holdings (i.e., principal residence, vacation homes, and other real estate holdings). The estimated value of vehicles is often included in wealth estimates, but other consumer durables, personal home furnishings, and jewelry are often excluded. Net worth represents the sum of total assets (financial, real estate, other) less debt (e.g., mortgages, business debt, car loans, educational loans, credit card debt).

The value of an asset may vary widely, depending upon particular market conditions. For example, a precipitous drop or dramatic rise in the stock market will affect the "paper" net worth of those holding stocks. To the degree that stock ownership is concentrated among the most wealthy, contractions in the stock market may result in an apparent decline in the concentration of wealth, and expansions in an apparent increase in concentration. Estimating the value of an asset may be subject to error, depending upon an individual's assessment of how much an asset might command subject to being sold or converted to cash at a particular moment. Aggregate income and asset amounts derived from household surveys typically underestimate the values obtained from institutional benchmarks of income and assets.

For some types of assets, reliable estimates may be deemed to be unattainable. For example, pension claims (including Social Security and Medicare benefits) represent the major asset, other than a home, held by most individuals. However, the value of an individual's pension assets are especially difficult to estimate. Few individuals know what their pensions are worth, especially when their value is contingent upon one's future employment and earnings, interest, inflation, and expected mortality. Consequently, pension holdings are usually not included in estimates of the distribution or concentration of personal wealth, even though they may constitute a major source of future income. Their exclusion may make the distribution of wealth appear to be somewhat more concentrated toward the upper end than it would otherwise.

Several methods have been employed to study the composition, value, and concentration of personal wealth in the United States.

---

[1] This section was written for the Committee on Ways and Means by Tom Gabe, Congressional Research Service.

Methods of collecting information on wealth may differ in their ability to effectively target and collect information on the very wealthy. To the degree that wealth is highly concentrated, failure of a particular method to capture the very wealthy will affect measures attempting to estimate aggregate wealth and its concentration.

THE CONCENTRATION OF WEALTH OVER TIME

Estimates of the share of wealth held by top wealthholders using Internal Revenue Service data on the estates of deceased citizens has been used to estimate the concentration of wealth among the population. Data from several sources are available for selected years covering the period from 1922 to 1982.[2] The *estate multiplier* method uses estate tax returns filed with the Internal Revenue Service (IRS) and estimated mortality rates, to infer from decedents the value of assets held by living estateholders. One advantage of this approach is that the data source captures the very wealthiest.[3] The estate multiplier method has been used to estimate the concentration of wealth held by the most wealthy, the top one or one-half percent of the population, over time.

Estimates using the estate multiplier methodology are shown in figure 1 and table 1. The figure shows that personal wealth is highly concentrated, but that the degree of concentration is less in the most recent period than in the past. The figure shows that the top 1 percent of wealthholders held about 19.7 percent of all personal wealth in 1982, representing a net worth of approximately $1.7 trillion in that year.[4] The concentration of wealth held by the richest 1 percent of adults was greatest just prior to the great depression; this group held over 36.3 percent of personal wealth (net of liabilities) in 1929. The concentration of wealth generally declined over the period marked by the great depression through the end of World War II. In 1949, the share of wealth held by the top 1 percent was lower than at any time in the prior 27 years. Wealth became more concentrated during the 1950s and 1960s, reaching a peak in 1965, with topmost wealthholders accounting for 31.3 percent of personal net worth. The concentration of wealth showed a decline from 1972 to 1976, with topmost wealthholders accounting for between 19.2 and 20.8 percent of personal net worth in 1976, depending upon the estimate used.

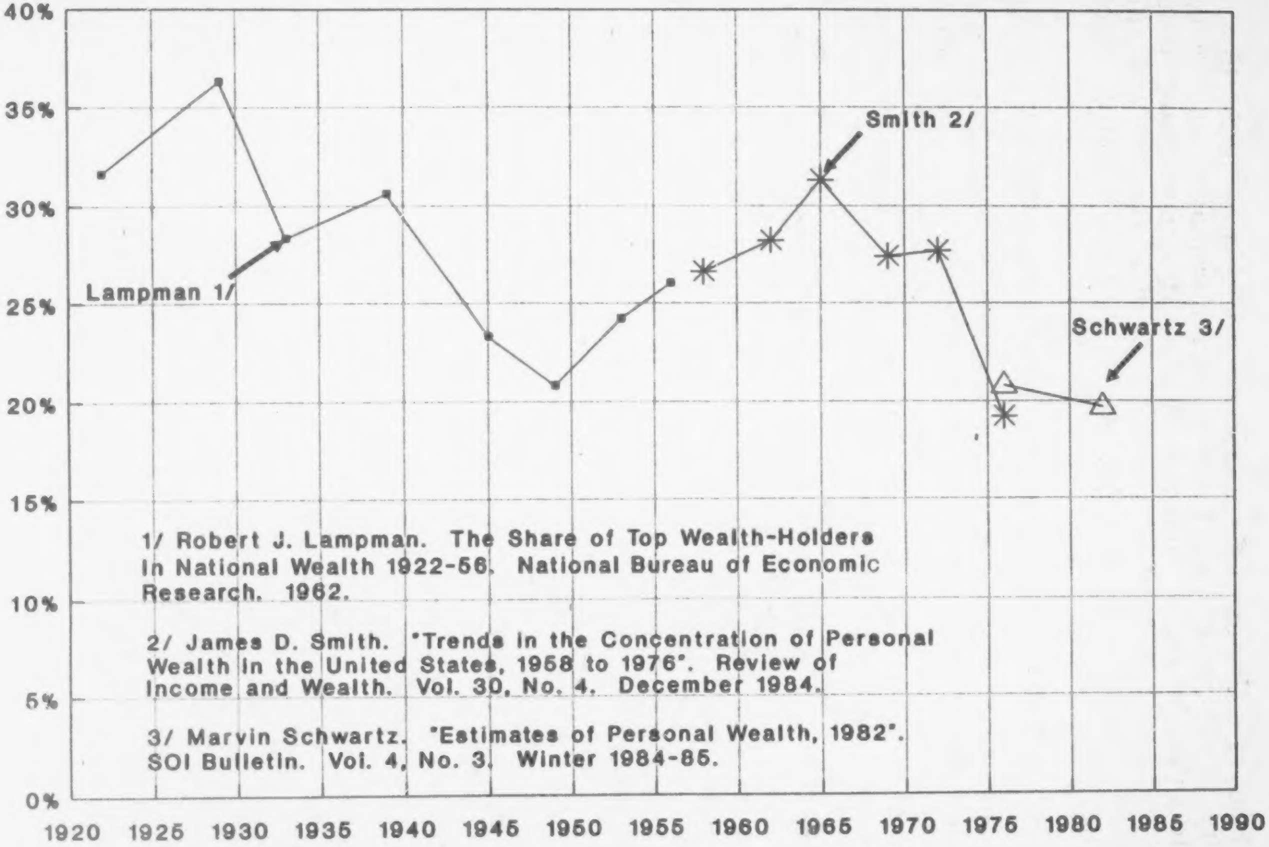
---

[2] See the following: Lampman, Robert J. "The Share of Top Wealth-Holders in National Wealth 1922-56." National Bureau of Economic Research, Inc., 1962. Smith James D. "Trends in the Concentration of Personal Wealth in the United States, 1958 to 1976." Review of Income and Wealth, v. 30, No. 4, December 1984. Schwartz, Marvin. "Estimates of Personal Wealth, 1982" SOI Bulletin, v. 4, No. 3, winter 1984-85.

[3] Estate tax forms are required only for the wealthiest of decedents. In 1986, estate tax forms were required for citizens who died having gross estates in excess of $500,000. Decedents with estates in excess of $500,000 in 1986 represented about 2 percent of the total U.S. population who died in that year. See: Johnson, Barry W. "Estate Tax Returns, 1986-1988." SOI Bulletin, v. 9. No. 4, spring 1990.

[4] Schwartz, "Estimates of Personal Wealth, 1982."

CHART 1. SHARE OF NET PERSONAL WEALTH HELD BY THE TOP 1 PERCENT OF WEALTHHOLDERS: 1922–82



1/ Robert J. Lampman. The Share of Top Wealth-Holders in National Wealth 1922-56. National Bureau of Economic Research. 1962.

2/ James D. Smith. "Trends in the Concentration of Personal Wealth in the United States, 1958 to 1976". Review of Income and Wealth. Vol. 30, No. 4. December 1984.

3/ Marvin Schwartz. "Estimates of Personal Wealth, 1982". SOI Bulletin. Vol. 4, No. 3. Winter 1984-85.

Note: all estimates are based on "estate multiplier" methods applied to IRS estate tax data.

TABLE 1.—ESTIMATES OF THE SHARE OF NET WORTH HELD BY THE MOST WEALTHY, 1922 TO 1982

Year	Lampman:[1] Share of equity held by top 1 percent of adults	Smith:[2] Net worth held by top 1 percent of U.S. population	Schwartz:[3] Share of net worth held by top 1 percent of adults
1922	31.6		
1929	36.3		
1933	28.3		
1939	30.6		
1945	23.3		
1949	20.8		
1953	24.2		
1956	26.0		
1958		26.6	
1962		28.2	
1965		31.3	
1969		27.4	
1972		27.7	
1976		19.2	20.8
1982			19.7

[1] Lampman, Robert J. "The Share of Top Wealth-Holders in National Wealth 1922–65." National Bureau of Economic Research, 1962.

[2] Smith, James D. "Trends in the Concentration of Personal Wealth in the United States, 1958 to 1976." Review of Income and Wealth, v. 30, No. 4, December 1984.

[3] Schwartz, Marvin. "Estimates of Personal Wealth, 1982." SOI Bulletin, v. 4, No. 3, winter 1984–85.

COMPOSITION AND CONCENTRATION OF ASSET HOLDINGS

One drawback of the estate multiplier data is the lack of information about the characteristics of individuals and the assets they hold. Estimates from the 1983 Survey of Consumer Finances (SCF),[5] provide some information on the types and value assets held by various types of households.

Table 2 shows the composition of asset holdings according to households' percentile ranking on total net worth. The table shows, for example, that home ownership represents the major source of wealth for all but the most wealthy households. In 1983, home ownership accounted for about 56 percent of the total wealth held by households with total net worth below the 90th percentile (the bottom 90 percent of households ranked by total net worth). Savings, money market accounts, and certificates of deposit represented the next major source of wealth (absent information on pension holdings) held by these households, representing nearly 12 percent of their total wealth. The average amount held in these accounts was $6,862 (i.e., $518.3 billion/75.5 million households). Public stock holdings of these households accounted for about 2 percent of their total wealth. Consumer and mortgage debt of these households amounted to about 23 percent of their gross assets.

---

[5] The Survey of Consumer Finances is based on a cross-section sample of households supplemented by high income households identified through IRS tax records. The Survey of Consumer Finances has also collected data on household asset holdings in 1986 and 1989. However, little published asset data from these sources has been released as of this time.

The composition of assets held by the most wealthy differs considerably from that of others, being much more diversified. The major source of wealth held by the very wealthiest (the top one-half of 1 percent) of households was in the form of private business assets, amounting to 33 percent of their total wealth. Public stock and real estate holdings (other than the principal residence) each accounted for an additional 20 percent of total wealth, followed by bonds and trusts (13 percent).

TABLE 2.—COMPOSITION OF ASSETS AMONG HOUSEHOLDS BY HOUSEHOLDS' PERCENTILE RANKING OF TOTAL NET WORTH 1983

	All households		Percentile of total net worth							
			0 to 90th percentile		90 to 99th percentile		99 to 99½ percentile		99½ to 100th percentile	
	Amount (billions)	Percent of gross assets	Amount (billions)	Percent of gross assets	Amount (billions)	Percent of gross assets	Amount (billions)	Percent of gross assets	Amount (billions)	Percent of gross assets
Gross assets	$11,562.0	100.0	4,380.9	100.0	$3,826.2	100.0	$784.0	100.0	$2,570.9	100.0
Principal residence	3,746.0	32.4	2,446.5	55.8	968.8	25.3	140.6	17.9	172.1	6.7
Other real estate (gross)	1,687.5	14.6	339.5	7.7	676.1	17.7	112.9	14.4	499.1	19.4
Public stock	1,041.1	9.0	104.5	2.4	334.7	8.7	87.3	11.1	514.7	20.0
Bonds and trusts	676.4	5.9	45.3	1.0	239.3	6.3	46.1	5.9	345.6	13.4
Checking accounts	119.4	1.0	65.3	1.5	37.6	1.0	6.6	.8	9.9	.4
Savings, CD's money market	1,049.1	9.1	518.3	11.8	383.7	10.0	45.9	5.9	101.2	3.9
Life insurance cash value	284.7	2.5	176.1	4.0	61.3	1.6	13.1	1.7	34.2	1.3
Business assets (net)	2,284.3	19.8	212.1	4.8	911.9	23.8	309.8	39.5	850.5	33.1
Automobiles	373.3	3.2	295.8	6.8	65.2	1.7	5.7	.7	6.6	.3
Miscellaneous	300.1	2.6	117.4	2.7	129.7	3.4	16.0	2.0	37.0	1.4
Debt	1,507.6	13.0	1,024.4	23.4	299.0	7.8	60.0	7.7	124.2	4.8
Consumer debt	318.9	2.8	221.0	5.0	48.8	1.3	22.1	2.8	27.0	1.1
Principal residence debt	864.6	7.5	689.0	15.7	140.2	3.7	21.3	2.7	14.1	.5
Other real estate debt	324.1	2.8	114.5	2.6	109.9	2.9	16.5	2.1	83.1	3.2
Net worth	10,054.4	87.0	3,356.5	76.6	3,527.2	92.2	724.0	92.3	2,466.7	95.2
Income (gross)	2,254.1	19.5	1,632.8	37.3	430.9	11.3	59.8	7.6	130.7	5.1
Number of households		83,917,968		75,530,720		7,546,222		421,200		419,827
Minimum wealth		−$73,400		−$73,400		$215,522		$1,376,195		$2,295,392
Maximum wealth		$86,852,000		$215,425		$1,373,405		$2,292,381		$86,852,000

Adapted from: Avery, Robert B., Gregory E. Elliehausen and Arthur B. Kennickell. "Measuring Wealth With Survey Data: An Evaluation of the 1983 Survey of Consumer Finances." Review of Income and Wealth, Series 34, No. 4, December 1988.

Table 3 shows the concentration of assets held according to households' relative wealth. The table shows that wealth is more highly concentrated than income. While the top one-half of 1 percent of households accounted for 5.8 percent of gross income, they accounted for 24.3 percent of total net worth. The topmost wealthholders held about half of all public stock assets and half of all assets in bonds and trusts. Topmost wealthholders held about 30 percent of total real estate value (excluding principal residences).

TABLE 3.—CONCENTRATION OF PRIVATE WEALTH BY HOUSEHOLDS' PERCENTILE RANKING OF TOTAL NET WORTH, 1983

	Total	Percentile of total net worth			
		0 to 90th percentile	90 to 99th percentile	2d ½ percentile	Upper ½ percentile
Gross assets	100	37.9	33.1	6.8	22.2
Principal residence	100	65.3	26.3	3.8	4.6
Other real estate (gross)	100	23.7	40.1	6.7	29.6
Public stock	100	10.0	32.1	8.4	49.4
Bonds and trusts	100	6.7	35.4	6.8	51.1
Checking accounts	100	54.7	31.5	5.6	8.3
Savings, CD's, money market	100	49.4	36.6	4.4	9.6
Life insurance cash value	100	61.8	21.5	4.6	12.0
Business assets (net)	100	9.3	39.9	13.6	37.2
Automobiles	100	79.2	17.5	1.5	1.8
Miscellaneous	100	39.1	43.2	5.3	12.3
Debt	100	67.9	19.8	4.0	8.2
Consumer debt	100	69.3	17.5	6.9	8.5
Principal residence debt	100	79.7	16.2	2.5	1.6
Other real estate debt	100	35.3	33.9	5.1	25.7
Net worth	100	33.4	35.1	7.2	24.3
Income (gross)	100	72.4	19.1	2.7	5.8

Adapted From: Avery, Robert B., Gregory E. Elliehausen and Arthur B. Kennickell. "Measuring Wealth With Survey Data: An Evaluation of the 1983 Survey of Consumer Finances." Review of Income and Wealth, Series 34, No. 4, December 1988.

Estimates from the SCF show a greater concentration of wealth among households than the IRS estate multiplier methodology shows for persons. The SCF data show that the top 1 percent of household held 31.5 percent of total personal net worth in 1983, compared to estate multiplier estimates of IRS data showing the wealthiest 1 percent of the population holding 19.7 percent of total personal net worth in 1982, the nearest available year (see table 1). Data from the 1963 Survey of Financial Characteristics of Consumers (SFCC) shows that the wealthiest 1 percent of the population held 31.8 percent of total personal net worth in that year [6] Unlike the IRS estate multiplier data, the SFCC and SCF data show little or no change in the concentration of wealth held by the top 1 percent of households from 1963 to 1983. In comparison, the nearest estate multiplier estimates of wealth held by the wealthiest 1 percent of adults were 28.2 percent in 1962 [7] and 19.7 percent in 1982.[8]

NET WORTH AND HOUSEHOLD CHARACTERISTICS

Recent data from the Survey of Income and Program Participation (SIPP) provide some useful information on the characteristics of households and their income and assets.[9] Because the SIPP is a cross-sectional household survey, not augmented by high income or asset holding households, data from the SIPP are prone to underestimating aggregate wealth and its concentration among households. For this reason, data from the SIPP are best suited to representing the asset holdings of households that are more typical than the wealthy or very wealthy. SIPP data are especially useful in gaining an understanding of how the composition and value of assets differ among households according to other characteristics, such as age, marital status, and race/ethnicity.

Table 4 shows the median net worth (and net worth less home equity) of households in 1988 according to the age of householder and monthly income quintile. The median reflects the dollar amount at which half the group has less, and half has more. The table shows that while median earnings are highest among those in the age 45 to 54 group, net worth is highest among those in the 65 to 69 age group. Consistent with the SCF data discussed above, the SIPP data show that home equity represents the major source of household wealth. As with the IRS estate multiplier data and SCF data, discussed above, the values of pension assets are not included here. The table suggests that households in the lowest fifth of the income distribution may have little in the way of assets to cushion any loss of current income. Median net worth excluding home equity of these households amounted to $1,152; for the youngest in this group, only $448.

---

[6] From Avery, Elliehausen, and Kennickell. SFCC data are similar to the SFC data, in that high income households were over-sampled.

[7] Smith "Trends in Concentration of Personal Wealth in the United States, 1958 to 1976."

[8] Schwartz, "Estimates of Personal Wealth, 1982."

[9] Data presented in this section are from: U.S. Bureau of the Census, Current Population Reports. Series P-70. No. 22. Household Wealth and Asset Ownership: 1988. U.S. Government Printing Office, Washington, DC, 1990.

TABLE 4.—MEDIAN NET WORTH, BY AGE OF HOUSEHOLDER AND MONTHLY HOUSEHOLD INCOME QUINTILE: 1988

Monthly household income	Total	Less than 35 years	35 to 44 years	45 to 54 years	55 to 64 years	65 years and over			
						Total	65 to 69 years	70 to 74 years	75 years and over
All households (thousands)	91,554	25,379	19,916	13,613	13,090	19,556	6,331	5,184	8,041
Median monthly income	$1,983	$2,000	$2,500	$2,604	$2,071	$1,211	$1,497	$1,330	$977
Median net worth	$35,752	$6,078	$33,183	$57,466	$80,032	$73,471	$83,478	$82,111	$61,491
Less home equity	$9,840	$3,258	$8,993	$15,542	$26,396	$23,856	$27,482	$28,172	$18,819
Lowest income quintile [1]									
Households (thousands)	18,299	4,642	2,270	1,630	2,467	7,290	1,800	1,647	3,842
Median net worth	$4,324	$652	$848	$2,803	$16,545	$25,220	$23,679	$28,880	$25,291
Less home equity	$1,152	$448	$441	$897	$1,541	$3,536	$3,055	$3,058	$4,474
Second income quintile [1]									
Households (thousands)	18,253	5,460	3,112	1,894	2,407	5,380	1,615	1,534	2,230
Median net worth	$19,964	$2,551	$7,536	$17,159	$51,641	$76,050	$73,712	$77,355	$76,253
Less home equity	$5,454	$1,823	$2,345	$4,046	$13,319	$28,168	$25,962	$26,958	$31,853
Third income quintile [1]									
Households (thousands)	18,378	6,186	4,007	2,325	2,480	3,380	1,356	924	1,100
Median net worth	$28,044	$6,440	$20,008	$38,295	$84,627	$141,811	$122,848	$142,501	$159,032
Less home equity	$8,418	$3,393	$5,045	$9,082	$27,627	$57,026	$47,032	$57,022	$77,922
Fourth income quintile [1]									
Households (thousands)	18,310	5,694	5,025	3,049	2,583	1,959	850	578	530
Median net worth	$46,235	$15,420	$39,983	$65,794	$96,066	$201,562	$180,802	$217,572	$222,320
Less home equity	$14,376	$6,933	$11,539	$18,809	$36,531	$100,480	$86,319	$121,341	$121,816
Fifth income quintile [1]									
Households (thousands)	18,314	3,397	5,502	4,715	3,152	1,548	710	500	338
Median net worth	$111,770	$37,817	$88,293	$130,867	$198,987	$343,015	$301,719	$370,695	$390,649
Less home equity	$40,688	$16,572	$30,766	$45,799	$91,888	$208,789	$171,183	$245,396	$252,058

[1] Quintile upper limits for 1988 were: Lowest quintile–$939; second quintile–$1,699; third quintile–$2,568; fourth quintile–$3,883.

Source: U.S. Bureau of the Census. "Current Population Reports," Series P–70, No. 22, Household Wealth and Asset Ownership: 1988.

Table 5 shows median net worth by age and type of household. The table shows married couples' median net worth is many times that of their nonmarried counterparts. For example, female householders age 55 to 64 had a total median net worth, less home equity, of $7,004, compared to $42,737 for married couples of similar age. The greater wealth of married couple families may in part be attributable to the greater earnings power of two worker families and the conversion of such earnings into assets.

TABLE 5.—NUMBER OF HOUSEHOLDS, MEDIAN MONTHLY HOUSEHOLD INCOME, AND MEDIAN NET WORTH BY HOUSEHOLD TYPE AND AGE OF HOUSEHOLDER: 1988

Household type and age of householder	Number of households (thousand)	Median monthly household income	Median net worth	
			Total	Less home equity
Married-couple households	51,697	$2,566	$57,134	$16,293
Less than 35	13,357	2,430	12,041	4,705
35 to 54	21,437	3,173	61,611	16,922
55 to 64	8,186	2,589	120,158	42,737
65 plus	8,736	1,733	124,419	45,890
Male householders	14,383	1,661	13,053	5,454
Less than 35	5,592	1,790	4,959	3,395
35 to 54	4,857	1,999	17,055	6,099
55 to 64	1,586	1,430	34,722	10,682
65 plus	2,346	1,023	48,883	15,914
Female householders	25,437	1,109	13,571	3,633
Less than 35	6,430	1,187	1,378	978
35 to 54	7,236	1,616	10,945	2,936
55 to 64	3,336	1,209	40,796	7,004
65 plus	8,471	780	47,233	10,693

Source: U.S. Bureau of the Census. "Current Population Reports," Series P–70, No. 22, Household Wealth and Asset Ownership: 1988.

Table 6 shows median net worth by race/ethnicity and type of household. The table shows that white households have total net worth that is 10 times that of black households, and nearly 8 times that of Hispanic households. Part of the disparity between white and black households' median net worth is attributable to differences in household composition; 59 percent of white households are married couples, compared to only 35 percent of black households (55 percent of Hispanic households are married couples). Part of the disparity between white and Hispanic households net worth is likely due to age differences, with Hispanic householders being younger, on average, than their white counterparts. Controlling for type of household, white married couple households have a median total net worth ($62,386) that is 3½ times that of black married couple households ($17,635) and 4 times that of Hispanic married couple families ($15,691). The disparity between white female householders' total net worth and that of their black and Hispanic counterparts is even greater than for married couple families. White female householders have a total median net worth of

$22,099, compared to $757 for black female householders and $736 for Hispanic female householders. Part of the difference between white female householders net worth and that of their black and Hispanic counterparts may be related to age differences. White female householders are on average older than their black and Hispanic counterparts, and are more likely to have been married at some time during their life. Their greater net worth may thus in part reflect a greater period over which wealth may have accumulated, as well as inheritance or divorce claims to assets that had accumulated while married.

TABLE 6.—NUMBER OF HOUSEHOLDS AND MEDIAN NET WORTH, BY RACE/ETHNICITY AND TYPE OF HOUSEHOLD: 1988

Type of household	Total	White	Black	Hispanic [1]
Number of households (thousands):				
All households	91,554	79,169	10,278	5,916
Married-couple households	51,697	46,766	3,630	3,281
Male householders	14,383	12,051	1,927	1,011
Female householders	25,437	20,352	4,721	1,625
Median net worth:				
All households	$35,752	$43,279	$4,169	$5,524
Married-couple households	$57,134	$62,386	$17,635	$15,691
Male householders	$13,053	$16,584	$1,457	$2,973
Female householders	$13,571	$22,099	$757	$736

[1] Hispanics may be of any race.

Source: U.S. Bureau of the Census. "Current Population Reports," Series P–70, No. 22, Household Wealth and Asset Ownership: 1988.

Table 7 shows median net worth and the distribution of net worth by monthly household income quintile, in 1988 and 1984, from the SIPP. Consistent with the IRS estate tax multiplier data and SCF data described earlier, the table shows a greater concentration of wealth among those having the highest income. For example, households in the top income quintile owned 44 percent of total net worth in 1988, and 47 percent of net worth in 1984. Except for the highest income group showing a somewhat lesser share of total wealth in 1988, as opposed to 1984, the distributions of household net worth in 1988 and 1984 are otherwise quite similar. It should be noted that these estimates may understate somewhat the share of total wealth held by the top income quintiles, since the SIPP does not oversample high income or high asset holding households. The table shows that the median net worth of households in the top income quintile was $111,770 in 1988, compared to $98,411 in 1984 (converted to 1988 dollars), a statistically significant increase over 1988. In other words, half of all households in the top fifth of the income distribution had net assets of

$111,770 or more in 1988, compared to $98,411 for the top fifth of the income distribution in 1984.

It may be speculated that the higher median net worth of the highest income quintile in 1988 than in 1984, may be reconciled with the lower percentage of total net worth received by this group in 1988 than in 1984 due to differences in assets held by the very wealthiest. The median net assets of the highest income quintile represents assets at the 90th percentile of total income. As shown earlier, by the SCF data, the composition and concentration of asset holdings of the wealthy and very wealthy differ considerably from others. The precipitous drop in stock market prices in the fall of 1987 might account for the smaller share of total net worth held by the highest income quintile in 1988 compared to 1984, even though the median net asset amounts held by the highest income quintile increased over this period.

TABLE 7.—MEDIAN NET WORTH AND DISTRIBUTION OF NET WORTH, BY MONTHLY HOUSEHOLD INCOME QUINTILE: 1988 AND 1984

	1988			1984 (in 1988 dollars)		
	Number of households (thousands)	Median net worth	Distribution of net worth	Number of households (thousands)	Median net worth	Distribution of net worth
Total	91,554	$35,752	100.0	88,871	$37,012	100.0
Monthly income quintile [1]:						
Lowest quintile	18,299	4,324	7.0	17,369	5,130	7.2
Second quintile	18,253	19,694	12.3	17,353	21,248	11.9
Third quintile	18,378	28,044	15.7	17,395	29,459	14.0
Fourth quintile	18,310	46,253	20.6	17,376	49,947	19.4
Highest quintile	18,314	111,770	44.4	17,378	98,411	47.5

[1] Quintile upper limits for 1988 were: Lowest quintile–$939; second quintile–$1,699; third quintile–$2,568; fourth quintile–$3,883. Upper limits for 1984 were: Lowest quintile–$811; second quintile–$1,471; third quintile–$2,221; fourth quintile–$3,298.

Source: U.S. Bureau of the Census. "Current Population Reports," Series P–70, No. 22, Household Wealth and Asset Ownership: 1988.

APPENDIX L. FEDERAL SPENDING ON CHILDREN AND THE ELDERLY

The Federal Government does not have a uniform data system across Government programs which would classify Government expenditures by age of recipient. This section describes two separate studies which estimate Government expenditures by type of recipient (children and the elderly). The first study was done by the Congressional Budget Office (CBO) and the second study was done by the minority staff of the House Budget Committee.

FEDERAL SPENDING ON THE ELDERLY

After decades of rapid growth, Federal spending on the elderly stabilized somewhat in the mid- and late-1980s (see table 1). The Federal Government spent at least $358 billion on the elderly in 1990, roughly five times what it spent on this age group 25 years earlier in real terms.[1] Per capita spending on the aged (in 1990 dollars) rose at an average annual rate of 4.4 percent over the same period, although this rate of growth slowed to 1.5 percent during the 1985–1990 period.

Federal spending on the elderly accounted for 28.5 percent of total Federal expenditures in 1990, up from about 16 percent in 1965 and 23.4 percent in 1980. Benefits for the aged totaled over 46 percent of nondefense, noninterest spending in 1990, and equalled about 6.6 percent of the gross national product.

Benefit outlays in these health programs rose by almost 60 percent during the 5-year period, three-fifths faster than the growth rate for other spending on older Americans.

FEDERAL SPENDING ON CHILDREN

Data on Federal spending directed toward children are not maintained by any single Federal agency. Consequently, such data may be obtained only by piecing together certain programmatic and survey information, and any resulting tabulation of Federal spending on children is imprecise. In some cases, such as Aid to Families With Dependent Children (AFDC), there is little ambiguity; in others, such as food stamps, benefits are scaled to the size of the recipient unit, but there is no requirement for children to be part of the recipient unit. In still others, such as Federal employee retirement programs, benefits to families with children may more properly be classified as deferred compensation tied directly to the Federal employment.

---

[1] Note that the estimates are somewhat imprecise because of the lack of good data on the distribution of benefits by age in several programs. Moreover, programs such as veterans' medical benefits provide assistance to the aged and nonaged alike, but because it is not possible to estimate the elderly/nonelderly shares, these programs are not included in the calculations.

TABLE 1.—ESTIMATED FEDERAL SPENDING FOR THE ELDERLY UNDER SELECTED PROGRAMS, FISCAL YEARS 1965–1990

[In current dollars]

Program	1965	1971	1975	1980	1985	1990
Social Security	(1)	27.1	51.8	81.2	140.4	192.7
Railroad Retirement	(1)	1.7	2.8	3.6	4.7	3.4
Federal civilian retirement	(1)	2.3	5.5	7.8	13.7	22.8
Military retirement	(1)	.7	1.1	1.8	4.3	7.4
Benefits for coal miners [2]	(1)	.1	0.2	1.3	1.5	1.3
Supplemental Security Income [3]	(1)	1.4	1.8	2.3	3.2	3.3
Veterans pensions [4]	(1)	.9	1.5	3.3	5.4	7.4
Medicare	(1)	7.5	12.8	29.3	61.4	95.4
Medicaid	(1)	1.9	2.6	4.7	8.5	16.2
Food Stamps [5]	(1)	.2	1.0	0.5	0.6	1.1
Housing assistance [6]	(1)	.2	.4	2.3	4.5	5.2
Total (current dollars)	18.8	44.0	81.3	138.1	248.3	356.2
Total (1990 dollars)	71.3	134.1	192.9	221.6	299.7	356.2
Federal Spending for the Elderly Relative to Total Federal Outlays, the Size of the Elderly Population and GNP						
Spending for the elderly:						
Per Aged Person (in 1990 dollars)	3,860	6,540	8,500	9,000	10,940	11,290
As percent of total Federal outlays	15.9	20.9	24.5	24.4	27.3	28.5
As percent of total Federal outlays, excluding defense and net interest	31.9	37.8	36.5	35.7	45.8	46.4
As a percent of GNP	2.8	4.2	5.3	5.4	6.5	6.6

[1] Estimated total spending for the elderly in 1965 was taken from a source that did not report spending separately by program.

[2] Prior to 1980, represents benefits for miners' widows only.

[3] 1970 estimate represents grants to states for aid to the aged, blind and disabled.

[4] Includes other veterans' compensation beginning in 1980.

[5] Includes nutrition assistance to Puerto Rico.

[6] Adjusted to eliminate outlays resulting from changing the financing procedures for public housing. NA—Not available.

Note.—Conversion to 1990 dollars used fiscal year averages for the CPI-X1.

Sources.—Figures for 1990 calculated by the Congressional Budget Office. Program spending figures for 1971–85 from the 1986 Statistical Abstract of the United States. Total spending on the aged for 1965 from R. Clark and J. Menefee, "Federal Expenditures for the Elderly: Past and Future," The Gerontologist, April 1981.

Table 2 presents data on total spending in a variety of Federal programs that provide benefits to children under age 18 and their families, indicating that about $85 billion of Federal spending, or about 7 percent of total Federal spending was directed to these families. These estimates, which exclude administrative costs where possible, indicate that food stamps and Social Security provide the greatest Federal support for families with children. However, if required State matching payments were included, the two largest programs would be AFDC and Medicaid. Of the roughly $85 billion in assistance, about 46 percent was spent on in-kind benefits, 37 percent in cash benefits, and 17 percent in education and other services.

Assistance to families with children is also provided through the income tax code. Families with children may receive tax benefits under the earned income tax credit and the dependent care tax credit. In 1990, these tax credits provided about $9.1 billion in assistance to families with children. Tax preferences also exist under the personal exemptions claimed for dependent children, under salary reduction plans that may be used for child care expenses and other provisions.

Tables 3–6 comprise the second study which focused on Federal expenditures for programs targeted explicitly on children under age 18 or on the elderly (i.e., someone over age 65). Many Federal programs provide services or benefits to all types of families. Wherever possible, administrative data were used to determine what percentage of expenditures went to children versus the elderly. Sometimes these percentages are unknown. For example, the amount of title XX (Social Services Block Grant) targeted on children had to be estimated on the basis of an incomplete survey of participating States. Nevertheless, the data in these tables are probably the best estimates available of how Federal spending on children versus the elderly has changed over time.

As shown in table 3, real Federal expenditures on children declined by 4 percent between fiscal years 1978 and 1987 while real spending on the elderly grew by 52 percent over the same time period.

Tables 5 and 6 utilize budget obligations as the measure of Federal spending. Budget obligations are defined as commitments to pay out money by Federal departments and agencies. All data are in constant dollars.

In table 5, a number of programs were excluded for failing to meet the criteria of programs explicitly targeted on children. First, programs which were not targeted on children but which provided substantial assistance to children were excluded. For example, housing assistance was excluded even though low-income housing assistance programs, which are not explicitly targeted on children, nevertheless provide a large amount of assistance to families with children.

Second, State and local expenditures were excluded even though they contribute a large proportion of total government spending in such areas as education, social services and income support. State and local funds for education, for example, are excluded, even though Federal spending has remained quite minimal at only 7 percent of the total. Similarly, the sizable State/local expenditures required under Federal law for AFDC and Medicaid are not included nor are the amounts voluntarily provided by States to supplement such programs as Supplemental Security Income.

Third, Federal spending directly targeted on children of present and former employees was excluded on the grounds that the benefits were essentially operating costs analogous to employee benefits. Thus, large programs such as educational impact aid and benefits paid to survivors of Federal employees are excluded.

Finally, because the focus is on children under age 18, Federal spending for higher education is excluded.

The focus of table 6 is on Federal expenditures for programs explicitly targeted on the elderly. Again, a number of programs were excluded which are not specifically targeted on the elderly, such as public housing.

Second, State and local expenditures were excluded even though they account for a large proportion of spending in such areas as social services and health care.

Third, Federal spending on retired Government employees was excluded on the grounds that the benefits were essentially operating costs analogous to employee benefits. Consequently, payments to Federal military and civilian retirement systems were excluded.

Finally, Federal spending for the Pension Benefit Guaranty Corporation was excluded on the basis that this quasi-public agency is self-financed and essentially autonomous.

TABLE 2.—SPENDING FOR FEDERAL PROGRAMS BENEFITING CHILDREN

[In billions of dollars, fiscal year 1990]

Program	Total	Spending on children
Cash transfers:		
Social Security [1]	246.5	11.8
Railroad Retirement [1]	4.2	.0
Supplemental Security Income	11.5	.9
AFDC	10.3	10.3
Unemployment Compensation	17.5	8.0
Veterans' Compensation	10.7	.5
In-kind transfers:		
Food stamps [2]	14.8	12.0
Child nutrition [3]	7.5	7.5
Medicare [4]	107.2	.1
Medicaid	39.0	11.5
Housing Assistance [5]	15.3	7.5
Low income Home Energy Assistance Program	1.3	.6
Education:		
Compensatory Education	4.5	4.5
Impact Aid	.8	.8
Education for the Handicapped	1.6	1.6
Other programs	1.4	1.4

TABLE 2.—SPENDING FOR FEDERAL PROGRAMS BENEFITING CHILDREN—Continued

[In billions of dollars, fiscal year 1990]

Program	Total	Spending on children
Services and other aid:		
Child Support	.5	.5
Human Development [7]	2.5	1.9
Foster Care/Adoption Assistance	1.6	1.6
Work Incentives/JOBS	0.3	0.3
Maternal and Child Health	.6	.6
Immunization	.2	.2
Summer Youth Employment and Training	.7	.7
Juvenile Justice Program	.1	.1
Total (outlays)	500.4	84.9
Tax credits:		
Earned income tax credit:		
Outlay	4.4	3.8
Revenue loss	1.8	1.6
Dependent care credit	3.9	3.7
Total (tax credits)	10.1	9.1

---

[1] Net financial interchange with Railroad Retirement included in Social Security spending.

[2] Includes nutrition assistance to Puerto Rico.

[3] child nutrition includes school breakfast and lunches, special meal assistance, summer and child care feeding, special milk, and supplemental feeding program for women, infants, and children.

[4] Excludes $11.2 billion in premium collections.

[5] Housing assistance includes Section 8, public and Indian housing, rent supplements, and Sections 235 and 236.

[6] Spending includes administrative expenses of collection activities.

[7] Human Development includes Head Start, child abuse and family violence spending, programs for runaway and homeless youth, Title III services (none allocated to children), and developmental disabilities.

Note.—Where available, outlays are limited to program benefits and exclude administrative costs except where otherwise noted.

Source.—Budget of the United States Government, Fiscal Year 1992. Share of spending on children calculated by Congressional Budget Office.

TABLE 3.—ESTIMATED FEDERAL PROGRAM EXPENDITURES TARGETED ON CHILDREN

[Fiscal years 1978 and 1987, obligations in billions of current and constant dollars]

Program expenditures	Fiscal year 1978		Fiscal year 1987		Percent change, constant dollars
	Current	Constant	Current	Constant	
Income programs:					
Aid for families with dependent children	6.360	9.620	10.120	9.010	−6
Child support enforcement	.040	.070	.330	.290	314
Earned income tax credit (refundable portion)	.880	1.330	1.410	1.250	−6
Social Security (OASI)	4.890	7.400	7.140	6.350	−14
Social Security (DI)	1.360	2.050	1.840	1.630	−20
Railroad retirement insurance	.100	.160	.100	.090	−44
Subtotal	13.630	20.620	20.930	18.620	−10
Nutrition programs:					
Child nutrition programs	2.700	4.080	4.330	3.850	−6
Food stamps	4.660	7.050	9.410	8.370	19
Commodity assistance for child nutrition programs	.680	1.030	.810	.720	−30
Special milk program	.160	.230	.020	.020	−91
Supplemental assistance for women, infants and children (WIC)	.430	.650	1.660	1.480	128
Other nutrition programs	.030	.040	.050	.050	25
Subtotal	8.650	13.080	16.280	14.490	11
Social service programs:					
Foster grandparent	.030	.050	.060	.050	0
Social services-grants to States (title XX)	.880	1.330	1.350	1.200	−10
Head Start	.620	.940	1.130	1.010	7
Juvenile Justice Program	.100	.150	.070	.060	−60
Child welfare services (title IV–B)	.080	.120	.230	.200	67
Foster Care (title IV–E)	.210	.320	.720	.640	100
Adoption assistance (title IV–E)	NA	NA	.090	.080	....
Other social service programs	.070	.110	.160	.150	36
Subtotal	2.000	3.020	3.790	3.380	12
Education programs:					
Vocational education	.950	1.440	.750	.670	−53
School improvement programs (chapter 2)	.460	.690	.920	.820	19
Indian education	.210	.320	.380	.330	3
Bilingual, immigrant and refugee education	.130	.200	.190	.170	−15
Education for the handicapped	.460	.690	1.560	1.390	101
Compensatory education (chapter 1)	2.760	4.170	3.990	3.550	−15
4–H (extension service)	.070	.100	.070	.060	−40

TABLE 3.—ESTIMATED FEDERAL PROGRAM EXPENDITURES TARGETED ON CHILDREN—Continued

[Fiscal years 1978 and 1987, obligations in billions of current and constant dollars]

Program expenditures	Fiscal year 1978		Fiscal year 1987		Percent change, constant dollars
	Current	Constant	Current	Constant	
Other education programs	.010	.010	.040	.030	200
Subtotal	5.050	7.630	7.900	7.030	−8
Training and employment programs:					
Young Adult Conservation Corps (YACC)	.050	.080	.000	.000	−100
Youth community conservation and improvement projects	.110	.170	.000	.000	−100
Youth incentive entitlement pilot projects (YIEPP)	.120	.170	.000	.000	−100
Training and employment services for disadvantaged youth	.530	.800	.570	.510	−36
Summer program for disadvantaged youth	.750	1.140	.640	.570	−50
Job Corps	.380	.570	.640	.570	0
Other training and employment programs	.020	.030	.000	.000	−100
Subtotal	1.960	2.960	1.850	1.650	−44
Health programs:					
Medicaid	1.719	2.600	3.361	2.990	15
Maternal and child health	.410	.610	.500	.440	−28
Immunization	.020	.030	.090	.080	167
NIH, research for mothers and children	.070	.110	.190	.170	55
Other health programs	.040	.070	.080	.080	14
Subtotal	2.260	3.420	4.220	3.750	10
Total program expenditures	33.540	50.740	54.980	48.920	−4

Note: Obligations converted to constant dollars using CPI–U. Totals may not add due to rounding.
Source: House Budget Committee.

TABLE 4.—ESTIMATED FEDERAL EXPENDITURES FOR PROGRAMS TARGETED ON THE ELDERLY

[Fiscal years 1978 and 1987, obligations in billions of current and constant dollars]

	Fiscal year 1978		Fiscal year 1987		Percent change, constant dollars
	Current	Constant	Current	Constant	
Income programs:					
Old age retirement insurance (Social Security)	56.810	85.940	138.810	123.500	44
Special benefits for persons aged 72+ (Social Security)	.150	.220	.040	.030	−86
Old age survivors' insurance (Social Security)	13.040	19.730	32.510	28.920	47
Railroad retirement	2.640	4.000	4.050	3.600	−10
Railroad survivors' insurance	.990	1.500	1.620	1.440	−4
Supplemental security income	1.740	2.630	2.170	1.930	−27
Subtotal	75.370	114.020	179.200	159.430	40
Nutrition programs:					
Elderly feeding program (food donation program)	.030	.050	.130	.120	140
Commodity supplemental food program	.000	.000	.020	.010	NA
Title III—Part C—nutrition services	.250	.380	.420	.380	0
Food stamps	.490	730	1.270	1.130	55
Subtotal	.770	1.160	1.840	1.640	41
Social services:					
Administration on Aging	0.260	.390	.300	.270	−31
National Institute on Aging	.040	.050	.170	.150	200
Older Americans Volunteer Programs	.060	.090	.100	.090	0
Grants to States	NA	NA	.330	.290	NA
Other social services programs	.000	.000	.020	.020	NA
Subtotal	.360	.540	.920	.820	52
Education, employment and training programs:					
Senior Community Service Employment Program	.200	.300	.340	.300	0
Other education, employment and training program	.010	.020	.010	.010	50
Subtotal	.220	.320	.350	.310	−3
Health programs:					
Medicare	19.030	28.790	66.990	59.600	107
Medicaid	3.530	5.340	8.930	7.940	49
Other health programs	.010	.010	.020	.010	0
Subtotal	22.560	34.140	75.940	67.550	98

TABLE 4.—ESTIMATED FEDERAL EXPENDITURES FOR PROGRAMS TARGETED ON THE ELDERLY—Continued

[Fiscal years 1978 and 1987, obligations in billions of current and constant dollars]

	Fiscal year 1978		Fiscal year 1987		Percent change, constant dollars
	Current	Constant	Current	Constant	
Housing programs:					
Housing for the Elderly and Handicapped (Sec. 202)	.580	.870	.430	.390	−55
Mortgage Insurance-Rental Housing for the Elderly (Sec. 231)	.170	.260	.000	.000	−100
Weatherization Assistance	.020	.030	.050	.050	67
Loan Insurance for Nursing Homes (Sec. 252)	.110	.170	.210	.190	12
Subtotal	.880	1.340	.700	.620	−54
Total	100.160	151.520	258.950	230.380	52

Note: Obligations converted to constant dollars using CPI–U. Totals may not add due to rounding.

Source: House Budget Committee.

TABLE 5.—FEDERAL SPENDING FOR MAJOR PROGRAMS TARGETED ON CHILDREN: FISCAL YEARS 1973–88

[Outlays or payments in billion constant dollars]

	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Aid for families with dependent children	9.3	9.1	9.5	10.1	10.0	9.9	9.1	8.6	8.7	8.3	8.3	8.4	8.3	8.9	9.0	8.9
Earned income tax credit	NA	NA	NA	1.8	2.0	1.8	1.5	2.5	2.2	1.8	1.6	1.5	1.4	1.8	1.7	3.2
Outlay	NA	NA	NA	1.4	1.5	1.3	1.1	1.6	1.5	1.3	1.2	1.2	1.0	1.3	1.3	2.3
Revenue loss	NA	NA	NA	.4	.6	.4	.4	.9	.7	.5	.4	.3	.3	.5	.5	.8
Social Security (OASDI)	7.5	8.2	8.5	9.1	9.4	9.5	9.3	9.2	9.4	9.2	8.9	8.6	8.3	8.2	8.0	7.1
Education for the handicapped	.1	.1	.1	.2	.2	.3	.6	1.0	1.2	1.2	1.1	.8	.9	1.5	1.0	1.4
Compensatory education (chapter 1)	4.0	3.3	4.0	3.7	3.6	4.0	4.1	4.2	3.8	3.1	2.7	3.0	3.9	3.1	2.9	3.4
Head Start	.9	.8	.8	.8	.8	.9	1.0	.9	.9	1.0	.9	1.0	1.0	1.0	1.0	1.0
Child nutrition and special milk	1.5	1.6	2.9	3.3	4.5	4.0	4.2	4.4	4.0	3.2	3.3	3.5	3.5	3.5	3.6	3.7
Food stamps	4.1	4.6	7.1	8.2	7.3	7.0	6.8	9.1	9.8	9.2	10.2	9.3	8.9	8.8	8.6	8.8
Supplemental feeding programs (WIC and CSFP)	NA	NA	NA	.2	.4	.6	.8	.9	1.1	1.0	1.2	1.4	1.4	1.5	1.5	1.6
Medicaid	2.0	2.2	2.5	2.6	2.7	2.6	2.5	2.4	2.4	2.2	2.3	2.3	2.5	2.8	3.0	3.1
Total	29.3	29.9	35.5	41.6	42.9	42.4	41.4	45.8	45.7	41.9	42.1	41.2	41.5	42.9	42.1	45.2

Note: All data converted to constant dollars using the CPI-U. Transition quarter excluded from data.

Source: House Budget Committee.

TABLE 6.—FEDERAL SPENDING FOR MAJOR PROGRAMS TARGETED ON THE ELDERLY: FISCAL YEARS 1973–88

[Outlays or payments in billions of dollars]

	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Social Security	80.6	85.3	89.4	94.9	102.0	105.9	108.9	113.0	122.5	130.5	138.8	141.2	145.2	149.9	152.5	155.2
Old age insurance	66.2	68.7	72.2	76.9	82.7	85.9	88.5	91.7	99.6	106.1	113.2	115.0	118.1	121.5	123.5	125.6
Survivors' insurance	14.3	16.1	16.7	17.7	19.0	19.7	20.2	21.2	22.8	24.3	25.5	26.2	27.1	28.3	28.9	29.6
Special benefits	.6	.5	.4	.3	.3	.2	.2	.1	.1	.1	.1	.1	.1	0	0	0
Railroad retirement	4.5	4.5	4.7	5.1	5.2	5.5	5.9	5.1	5.1	5.2	5.3	5.2	5.4	5.0	5.1	5.0
Old age	3.3	3.3	3.4	3.6	3.7	4.0	3.6	3.6	3.6	3.7	3.7	3.6	3.9	3.6	3.6	3.5
Survivors' insurance	1.1	1.2	1.3	1.5	1.5	1.5	2.3	1.5	1.5	1.6	1.6	1.5	1.5	1.5	1.4	1.4
Supplemental security income	NA	1.7	3.2	3.0	2.8	2.6	2.4	2.2	2.2	2.1	2.0	2.1	2.0	2.0	1.9	1.9
Medicare	17.0	16.4	20.3	23.0	26.3	28.8	30.6	33.5	35.7	40.4	45.1	47.7	52.8	55.2	59.6	60.6
Medicaid	3.9	4.3	4.5	4.8	5.0	5.3	5.5	6.2	6.3	6.1	6.6	6.9	7.3	7.6	7.9	8.2
Total	106.0	112.2	122.0	130.8	141.2	148.1	153.3	160.0	171.8	184.4	197.8	203.0	212.8	282.1	227.0	230.9

Note: All data converted to constant dollars using the CPI–U. Transition quarter excluded from data.

Source: House Budget Committee.

APPENDIX M. SELECTED ECONOMIC, POPULATION, AND INCOME DATA FOR THE UNITED STATES AND BY STATE

TABLE 1.—THE GROSS NATIONAL PRODUCT, 1970–90

[In billions]

Calendar year	In current dollars	In constant 1982 dollars	Percentage change from preceding period (using constant 1982 dollars)
1970	1,015.5	2,416.2	
1971	1,102.7	2,484.8	2.8
1972	1,212.8	2,608.5	5.0
1973	1,359.3	2,744.1	5.2
1974	1,472.8	2,729.3	−.5
1975	1,598.4	2,695.0	−1.3
1976	1,782.8	2,826.7	4.9
1977	1,990.5	2,958.0	4.7
1978	2,249.7	3,115.2	5.3
1979	2,508.2	3,192.4	2.5
1980	2,732.0	3,187.1	−.2
1981	3,052.6	3,248.8	1.9
1982	3,166.0	3,166.0	−2.5
1983	3,405.7	3,279.1	3.6
1984	3,772.2	3,501.4	6.8
1985	4,014.9	3,618.7	3.4
1986	4,231.6	3,717.9	2.7
1987	4,515.6	3,845.3	3.4
1988	4,873.7	4,016.9	4.5
1989	5,200.8	4,117.7	2.5
1990[1]	5,463.0	4,155.8	.9

[1] Preliminary.

Source: Department of Commerce, Bureau of Economic Analysis.

TABLE 2.—PRICE LEVELS, 1970–1990

[1982–84 = 100]

Calendar year	GNP implicit price deflator	All items (CPI–U)	All items (CPI–U) (fiscal year)	Food and beverage [1]	Housing	Medical care	CPI–X1	CPI–X1 (fiscal year)
1970	42.0	38.8	37.8	40.1	36.4	34.0	41.3	40.3
1971	44.4	40.5	39.7	41.4	38.0	36.1	43.1	42.2
1972	46.5	41.8	41.2	43.1	39.4	37.3	44.4	43.7
1973	49.5	44.4	42.8	48.8	41.2	38.8	47.1	45.5
1974	54.0	49.3	46.6	55.5	45.8	42.4	51.9	49.3
1975	59.3	53.8	51.8	60.2	50.7	47.5	56.2	54.2
1976	63.1	56.9	[2] 55.5	62.1	53.8	52.0	59.4	[2] 57.9
1977	67.3	60.6	59.7	65.8	57.4	57.0	63.2	62.2
1978	72.2	65.2	63.9	72.2	62.4	61.8	67.5	66.2
1979	78.6	72.6	70.4	79.9	70.1	67.5	74.0	72.1
1980	85.7	82.4	80.0	86.7	81.1	74.9	82.2	80.1
1981	94.0	90.9	88.9	93.5	90.4	82.9	90.1	88.2
1982	100.0	96.5	95.4	97.3	96.9	92.5	95.6	94.4
1983	103.9	99.6	98.8	99.5	99.5	100.6	99.6	98.7
1984	107.7	103.9	102.9	103.2	103.6	106.8	103.9	102.9
1985	110.9	107.6	106.6	105.6	107.7	113.5	107.6	106.6
1986	113.8	109.7	109.3	109.1	110.9	112.0	109.7	109.3
1987	117.4	113.7	112.4	113.5	114.2	130.1	113.7	112.4
1988	121.3	118.4	117.1	118.2	118.5	138.6	118.4	117.1
1989	126.3	124.0	122.7	124.9	123.0	149.3	124.0	122.7
1990	[3] 131.5	130.7	128.8	132.1	128.5	162.8	130.7	128.8

[1] Includes alcoholic beverages, not shown separately. [2] In 1976, the fiscal year was moved from July-June to October-September. The 3-month period from July through September, 1976, is not represented in this table. The value for CPI–U during this period is 57.4; the value of CPI–X1 during this period is 59.8. [3] Preliminary.

Note: Data beginning 1978 are for all urban consumers; earlier data are for urban wage earners and clerical workers. Data for CPI–U beginning 1983 incorporate a rental equivalence measure for homeowners' costs (the measure used in determining CPI–X1) and therefore are not strictly comparable with earlier figures.

Source: Department of Labor, Bureau of Labor Statistics.

TABLE 3.—NET NATIONAL SAVING, NET DOMESTIC INVESTMENT, AND NET FOREIGN INVESTMENT AS PERCENTAGES OF NET NATIONAL PRODUCT, 1950–96

Calendar years	(1) Personal saving	(2) Retained earnings	(3) Net private saving (1) + (2)	(4) State and local surplus	(5) Federal surplus	(6) Government surplus (4) + (5)	(7) Net National saving (3) + (6)	(8) Net domestic investment	(9) Net foreign investment [1] (7) − (8)
1950–59	5.2	3.0	8.2	−0.2	0.1	−0.1	8.1	8.2	0.1
1960–69	5.1	3.8	8.9	.0	−.3	−.3	8.6	7.7	.7
1970–79	6.2	2.7	8.9	.9	−1.9	−1.1	7.9	7.6	.3
1980–89	4.2	1.9	6.2	1.4	−4.2	−2.8	3.4	5.1	−1.8
					History				
1980	5.6	1.6	7.2	1.1	−2.5	−1.4	5.8	5.5	.3
1981	5.9	1.6	7.5	1.3	−2.4	−1.1	6.4	6.2	.2
1982	5.5	.7	6.3	1.3	−5.2	−4.0	2.3	2.3	.0
1983	4.3	2.2	6.5	1.6	−5.8	−4.3	2.2	3.5	−1.3
1984	4.9	2.8	7.7	1.9	−5.1	−3.1	4.6	7.4	−2.9
1985	3.5	2.9	6.4	1.8	−5.5	−3.7	2.7	5.8	−3.1
1986	3.3	2.2	5.6	1.7	−5.5	−3.8	1.7	5.3	−3.6
1987	2.3	2.1	4.4	1.3	−3.9	−2.7	1.7	5.3	−3.6
1988	3.3	2.1	5.4	1.1	−3.3	−2.2	3.3	5.3	−2.1
1989	3.7	1.1	4.8	1.0	−2.9	−1.9	2.9	4.7	−1.7
1990	3.7	.6	4.3	.7	−3.3	−2.6	1.7	3.5	−1.8

TABLE 3.—NET NATIONAL SAVING, NET DOMESTIC INVESTMENT, AND NET FOREIGN INVESTMENT AS PERCENTAGES OF NET NATIONAL PRODUCT, 1950–96—Continued

Calendar years	(1) Personal saving	(2) Retained earnings	(3) Net private saving (1) + (2)	(4) State and local surplus	(5) Federal surplus	(6) Government surplus (4) + (5)	(7) Net National saving (3) + (6)	(8) Net domestic investment	(9) Net foreign investment[1] (7) − (8)
					CBO Forecast				
1991	3.6	0.3	3.8	.6	−3.3	−2.7	1.1	2.6	−1.4
1992	4.3	.8	5.1	.7	−2.8	−2.0	3.1	3.9	−.8
1993	4.4	.8	5.3	0.8	−2.2	−1.4	3.8	4.7	−.8
1994	4.5	.7	5.2	.7	−1.4	−.7	4.5	5.5	−1.0
1995	4.5	.6	5.1	.7	−1.1	−.4	4.7	5.8	−1.1
1996	4.3	.7	5.0	.7	−.9	−.2	4.8	6.0	−1.2

[1] Figures in column (9) do not exactly equal the difference between columns (7) and (8) because of statistical discrepancies and rounding.

Sources: U.S. Department of Commerce, Bureau of Economic Analysis; Congressional Budget Office.

TABLE 4.—POPULATION ESTIMATES BY STATE

State	Resident population July 1, 1988 (thousands) [1]	Resident population April 1, 1980 (census) (thousands)	Percentage change, total population 1980–88	Population 65 years and over, 1988 (thousands)	Percentage of population 65 and over
Total	245,807	226,546	8.5	30,367	12.4
Connecticut	3,233	3,108	4.0	435	13.5
Maine	1,205	1,125	7.2	161	13.4
Massachusetts	5,889	5,737	2.7	806	13.7
New Hampshire	1,085	921	17.9	123	11.3
Rhode Island	993	947	4.8	146	14.7
Vermont	557	511	9.0	66	11.8
Delaware	660	594	11.1	77	11.7
District of Columbia	617	638	−3.4	77	12.5
Maryland	4,622	4,217	9.6	498	10.8
New Jersey	7,721	7,365	4.8	1,009	13.1
New York	17,909	17,558	2.0	2,328	13.0
Pennsylvania	12,001	11,864	1.2	1,793	14.9
Illinois	11,614	11,427	1.6	1,421	12.2
Indiana	5,556	5,490	1.2	680	12.2
Michigan	9,240	9,262	−.2	1,076	11.6
Ohio	10,855	10,798	.5	1,372	12.6
Wisconsin	4,855	4,706	3.2	641	13.2
Iowa	2,834	2,914	−2.7	423	14.9
Kansas	2,495	2,364	5.6	338	13.5
Minnesota	4,307	4,076	5.7	540	12.5
Missouri	5,141	4,917	4.6	710	13.8
Nebraska	1,602	1,570	2.1	221	13.8
North Dakota	667	653	2.2	90	13.5
South Dakota	713	691	3.2	100	14.0
Alabama	4,102	3,894	5.4	513	12.5
Arkansas	2,395	2,286	4.7	350	14.6
Florida	12,335	9,746	26.6	2,201	17.8
Georgia	6,342	5,463	16.1	637	10.0
Kentucky	3,727	3,661	1.8	463	12.4
Louisiana	4,408	4,206	4.8	479	10.9
Mississippi	2,620	2,521	3.9	321	12.3
North Carolina	6,489	5,882	10.3	775	11.9
South Carolina	3,470	3,122	11.2	379	10.9
Tennessee	4,895	4,591	6.6	612	12.5
Virginia	6,015	5,347	12.5	640	10.6
West Virginia	1,876	1,950	−3.8	268	14.3
Arizona	3,489	2,718	28.4	447	12.8
New Mexico	1,507	1,303	15.6	155	10.3

TABLE 4.—POPULATION ESTIMATES BY STATE—Continued

State	Resident population July 1, 1988 (thousands) [1]	Resident population April 1, 1980 (census) (thousands)	Percentage change, total population 1980–88	Population 65 years and over, 1988 (thousands)	Percentage of population 65 and over
Oklahoma	3,242	3,025	7.2	422	13.0
Texas	16,841	14,229	18.4	1,666	9.9
Colorado	3,301	2,890	14.2	314	9.5
Idaho	1,003	944	6.2	118	11.8
Montana	805	787	2.3	103	12.8
Utah	1,690	1,461	15.7	141	8.3
Wyoming	479	470	2.1	45	9.4
California	28,314	23,668	19.6	3,011	10.6
Nevada	1,054	800	31.7	113	10.7
Oregon	2,767	2,633	5.1	381	13.8
Washington	4,648	4,132	12.5	551	11.9
Alaska	524	402	30.5	20	3.8
Hawaii	1,098	965	13.8	114	10.4

Source: U.S. Department of Commerce, Bureau of the Census, Population Estimates and Projections, Series P–25, No. 1044, August 1989.

TABLE 5.—TOTAL U.S. RESIDENT POPULATION, BY AGE GROUP, SELECTED YEARS, 1940–2020

[In thousands]

Year	Total	Age						
		0–5	6–15	16–19	20–24	25–44	45–64	65 and over
1940 [1] [2]	132,122	12,686	22,704	9,895	11,690	39,868	26,249	9,031
1945 [1] [2]	139,928	15,224	21,663	9,362	12,036	42,521	28,630	10,494
1950 [2]	152,271	19,125	24,006	8,542	11,680	45,673	30,849	12,397
1955 [2]	165,931	22,015	29,232	8,745	10,714	47,195	33,507	14,527
1960	179,979	24,300	34,536	10,568	10,868	46,848	36,184	16,675
1965	193,526	23,913	38,848	13,412	13,404	46,609	38,889	18,451
1970	203,984	20,923	41,059	15,187	16,579	48,149	41,981	20,107
1975	215,465	19,667	38,962	16,953	19,317	54,074	43,794	22,696
1980	227,225	19,639	35,663	17,105	21,380	63,257	44,507	25,704
1981	229,637	20,066	35,055	16,716	21,614	65,386	44,563	26,235
1982	231,996	20,583	34,591	16,203	21,587	67,611	44,596	26,825
1983	234,284	20,964	34,355	15,665	21,489	69,713	44,672	27,426
1984	236,477	21,251	34,236	15,104	21,328	71,777	44,811	27,971
1985	238,736	21,552	34,144	14,784	21,000	73,791	44,926	28,540
1986	241,107	21,759	34,100	14,764	20,411	75,848	45,050	28,174
1987	243,427	21,918	34,035	14,921	19,791	77,619	45,302	28,841
1988	245,785	22,103	34,336	14,861	19,182	78,934	45,996	30,374
1989	248,239	22,357	34,836	14,534	18,702	80,337	46,489	30,984
1990 [3]	250,410	22,144	35,276	14,068	18,689	81,822	46,851	31,559
2000 [3]	267,748	20,417	37,714	15,174	17,404	80,785	61,373	34,882
2010 [3]	282,057	20,277	34,907	15,125	19,257	74,499	78,629	39,362
2020 [3]	293,846	20,590	35,253	14,071	17,735	76,416	77,714	52,067
Percentage Composition								
1940	100	9.6	17.2	7.5	8.8	30.2	19.9	6.8
1950	100	12.6	15.8	5.6	7.7	30.0	20.3	8.1
1960	100	13.5	19.2	5.9	6.0	26.0	20.1	9.3
1970	100	10.3	20.1	7.4	8.1	23.6	20.6	9.9
1980	100	8.6	15.7	7.5	9.4	27.8	19.6	11.3
1989	100	9.0	14.0	5.9	7.5	32.4	18.7	12.5
1990	100	8.8	14.1	5.6	7.5	32.7	18.7	12.6
2000	100	7.6	14.1	5.7	6.5	30.2	22.9	13.0
2010	100	7.2	12.4	5.4	6.8	26.4	27.9	14.0
2020	100	7.0	12.0	4.8	6.0	26.0	26.4	17.7
Percentage growth, 1989 to—								
2000	7.9	−8.7	8.3	4.4	−6.9	0.6	32.0	12.6
2010	5.3	−0.7	−7.4	−0.3	10.6	−7.8	28.1	12.8
2020	4.2	1.5	1.0	−7.0	−7.9	2.6	−1.2	32.3

---

[1] Excludes Alaska and Hawaii.

[2] Include Armed Forces overseas.

[3] Projected

Note: Includes Armed Forces overseas. Alaska and Hawaii beginning 1950.

Source: U.S. Bureau of the Census, Current Population Reports Series P–25, Nos. 311, 519, 917, 1045 and 1057.

TABLE 6.—PER CAPITA PERSONAL INCOME FOR STATES AND REGIONS, SELECTED YEARS, 1981–89

Area name	Based on State estimates of population [1]				Rank in U.S.
	Dollars				
	1981	1985	1988	1989	1989
United States	10,949	13,896	16,491	17,567	....
New England	11,701	15,950	20,171	21,509	....
Connecticut	13,487	18,227	23,039	24,604	1
Maine	9,025	11,903	15,088	16,310	25
Massachusetts	11,779	16,305	20,834	22,196	3
New Hampshire	10,901	15,367	19,230	20,251	7
Rhode Island	10,500	13,779	16,846	18,061	14
Vermont	9,562	12,373	15,303	16,399	24
Mideast	11,797	15,516	18,975	20,321	....
Delaware	11,265	14,547	17,693	19,116	9
District of Columbia	13,615	17,811	21,471	23,436	....
Maryland	11,945	15,970	19,565	21,020	5
New Jersey	12,954	17,618	22,146	23,764	2
New York	11,854	15,773	19,261	20,540	6
Pennsylvania	10,868	13,554	16,224	17,422	20
Great Lakes	10,945	13,694	16,242	17,387	....
Illinois	11,943	14,730	17,588	18,858	11
Indiana	10,054	12,424	14,856	16,005	28
Michigan	10,865	14,001	16,544	17,745	16
Ohio	10,556	13,176	15,530	16,499	22
Wisconsin	10,600	13,234	15,625	16,759	21
Plains	10,670	13,273	15,391	16,231	....
Iowa	10,815	12,619	14,680	15,524	31
Kansas	11,189	13,812	15,736	16,182	27
Minnesota	11,015	14,144	16,649	17,746	15
Missouri	10,320	13,250	15,458	16,431	23
Nebraska	10,651	12,967	14,783	15,360	33
North Dakota	10,148	11,951	12,764	13,261	43
South Dakota	9,248	11,029	12,741	13,244	44
Southeast	9,413	12,044	14,461	15,423	....
Alabama	8,467	10,698	12,845	13,679	41
Arkansas	8,319	10,525	12,212	12,984	48
Florida	10,818	13,935	16,603	17,694	17
Georgia	9,306	12,616	15,273	16,188	26
Kentucky	8,904	10,768	12,830	13,777	39
Louisiana	9,816	11,302	12,298	13,041	46
Mississippi	7,658	9,249	11,123	11,835	50
North Carolina	8,879	11,662	14,293	15,221	34
South Carolina	8,372	10,729	12,934	13,616	42
Tennessee	8,810	11,252	13,859	14,765	35
Virginia	10,901	14,468	17,671	18,970	10
West Virginia	8,536	10,073	11,696	12,529	49

TABLE 6.—PER CAPITA PERSONAL INCOME FOR STATES AND REGIONS, SELECTED YEARS, 1981–89—Continued

Area name	Based on State estimates of population[1]				Rank in U.S.
	Dollars				
	1981	1985	1988	1989	1989
Southwest	10,802	13,090	14,361	15,231	...
Arizona	10,094	12,957	15,000	15,881	29
New Mexico	9,022	11,197	12,469	13,191	45
Oklahoma	10,687	12,139	13,355	14,151	36
Texas	11,122	13,476	14,592	15,483	32
Rocky Mountain	10,575	12,683	14,355	15,316	...
Colorado	11,864	14,699	16,465	17,494	19
Idaho	9,274	10,817	12,596	13,762	40
Montana	9,872	11,015	12,896	13,852	38
Utah	8,660	10,653	12,180	13,027	47
Wyoming	12,331	12,834	13,634	14,135	37
Far West	12,378	15,481	18,138	19,153	...
California	12,723	16,035	18,757	19,740	8
Nevada	12,376	14,693	17,521	18,827	12
Oregon	10,440	12,628	14,876	15,785	30
Washington	11,626	14,076	16,452	17,640	18
Alaska	15,486	18,785	19,042	21,173	4
Hawaii	11,273	13,900	16,775	18,306	13

---

[1] Per capita personal income was computed using Bureau of the Census State population estimates as of December 1989.

Source: Survey of Current Business, April 1990.

TABLE 7.—U.S. RESIDENT POPULATION FOR PERSONS UNDER 18 AND OVER AGE 65, 1970–89

[In thousands]

Year	Total	Age	
		0–17	65 and over
1970	203,984	69,759	20,107
1971	206,827	69,806	20,561
1972	209,284	69,417	21,020
1973	211,357	68,762	21,525
1974	213,342	67,984	22,061
1975	215,465	67,164	22,696
1976	217,563	66,250	23,278
1977	219,760	65,461	23,892
1978	222,095	64,773	24,502
1979	224,567	64,106	25,134
1980	227,255	63,694	25,704
1981	229,637	63,284	26,235
1982	231,996	62,953	26,825
1983	234,284	62,780	27,426
1984	236,477	62,773	27,971
1985	238,736	62,979	28,540
1986	241,107	63,302	29,174
1987	243,427	63,560	29,841
1988	245,785	63,820	30,374
1989	248,239	64,083	30,984

Source: U.S. Bureau of the Census.

APPENDIX N. AFDC AND OTHER QUALITY CONTROL SYSTEMS

In the four major welfare programs, AFDC, SSI, Medicaid, and the food stamp program, the Federal Government and the States have established on-going "quality control" systems. These systems have two goals: correcting faults in program administration that contribute to erroneous payments and reducing the extent of misspent benefit dollars. To these ends, they attempt to: (1) measure the extent and dollar value of "errors" in administration; (2) identify the types and causes of error; and (3) specify and monitor corrective actions taken to eliminate or reduce errors.

Sanctions also have been made a part of these systems. States can be held liable for the cost of benefit payments made in excess of federally established error tolerance levels, often referred to as target error rates.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248) included target error rates for AFDC and Medicaid; the 1982 Omnibus Budget Reconciliation Act (P.L. 97-253) also established target error rates for the food stamp program.

The AFDC target error rate for fiscal year 1983 was set at 4 percent, and was reduced by TEFRA to 3 percent for fiscal year 1984 and thereafter. The AFDC quality control system and sanction rules were completely revised under the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), beginning for fiscal year 1991. Under the new system, penalties are imposed on States whose error rates are above the national average. This revised system is discussed in detail later in this section.

For Medicaid, a 3-percent target error rate was established under TEFRA for quarters beginning after March 30, 1983. Under Medicaid, prospective fiscal sanctions were authorized to be applied beginning in the second half of fiscal year 1983 for States with error rates exceeding 3 percent. However, errors, which, if corrected, would not have made a difference in the amount of medical assistance paid, are excluded from the calculation.

Under the food stamp law effective at the start of fiscal year 1983, fiscal sanctions were imposed on States unless they progressively reduced their payment error rates each year, and, beginning with fiscal year 1985, sanctions could be avoided only if error rates (payments to ineligible households and overpayments to eligible households) were less than a 5 percent "tolerance level." Earlier provisions had required States to have error rates below the national average, or show substantial progress in reducing errors, in order to avoid sanctions, but penalties were largely waived.

The food stamp quality control system and sanction rules were completely revised by the Hunger Prevention Act of 1988 (P.L. 100-435). Recognizing that the 5-percent tolerance level was too low (virtually all States were subject to substantial sanctions), that no sanctions were being collected because of appeals, and that underpayment errors were not reflected in sanction assessments, the 1988 act significantly raised the tolerance level for sanctions and included underpayment errors in setting sanctions. Retroactively to fiscal year 1986, the tolerance level was set at the lowest combined national average payment error rate (payments to ineligible households, overpayments, and underpayments) ever achieved, including the year under assessment, plus 1 percentage point. In fiscal year 1989, this tolerance level was 10.8 percent: a 7.3 percent national error rate for payments to ineligible households and overpayments, plus a 2.5 percent national underpayment error rate, plus 1 percentage point. The new law has, in effect, dropped the number of penalized States to well under 20 and significantly reduced the sanctions charged them. In a revised form, the new system also retained earlier fiscal incentives for States with very low payment error rates (those with combined error rates under 6 percent). In fiscal year 1989, eight States met this test for fiscal incentives.

While the 1988 act resolved most contentious issues for fiscal years beginning with 1986, set up a new appeals process for State/Federal differences over error rates and sanctions, and established rules for charging interest on uncollected sanctions, it did not address problems in earlier years, for which large sanction assessments were still outstanding. In the 1990 food stamp amendments included in the Food, Agriculture, Conservation, and Trade Act (P.L. 101-624), sanctions for fiscal year 1983-85 were forgiven.

MEASUREMENT OF ERROR

The core of the four existing quality control systems is the quality control case survey. Each system compiles the results of a statistically valid sample of cases ranging from 40,000 to 80,000 nationwide. For AFDC, food stamps, and SSI, the cases are now selected, and error data compiled, on an annual basis rather than every 6 months as in Medicaid. In the past, AFDC, food stamps, and SSI programs also collected quality control data every 6 months. Each selected case is subjected to a thorough review by quality control personnel, including a full field investigation. This review identifies payments to ineligibles, overpayments, underpayments, the type of error made, the responsibility (recipient versus administering agency) for the error, and, to a limited degree, incorrect denials of aid. Error "rates" are then established for that review period for each State: "caseload" error rates indicate the proportion of ineligible cases, overpaid cases, underpaid cases, and, in some cases, improperly denied cases in the sample caseload; "payment" error rates indicate the extent of erroneous payments as a proportion of total dollars paid out to the sampled caseload. Moreover, information on the sources and types of errors identified in each quality control review is compiled for use in implementing administrative "corrective actions" intended to reduce or eliminate similar errors in the future.

In the AFDC and food stamp systems, quality control error rates quantify the extent to which eligibility and payment errors exist in the State-administered caseloads of these two programs. In the Medicaid system, quality control error rates indicate the extent to which errors as to eligibility, overpayment, claims processing (payment of improper claims), and identification of third-party liability exist in the Medicaid population. And, in the SSI system, quality control error rates illustrate the extent and cost of errors in the federally administered caseload.

The "errors" identified and measured in all four quality control systems range from simple procedural or arithmetical mistakes, to lack of verification or nonreporting of income, to outright recipient fraud. As a result, although quality control error rates and the information behind them do give a picture of the extent to which improper decisions are being made and help administering agencies pinpoint areas where improvement is needed, they do not represent a statistically accurate measure of intentional actions such as fraud. In fact, "agency-caused" procedural errors make up nearly half the errors typically identified in quality control surveys, and "recipient-caused" errors may often be simple mistakes in understanding what is required or failure to provide correct information on a timely basis.

ADMINISTRATION

In the AFDC, Medicaid, and food stamp programs, the quality control systems are operated by State quality control staff under Federal instructions and guidelines. A State's error rate is determined by using findings from both the State's full sample and a Federal subsample. In the SSI program, the entire quality control system is federally operated since it measures the performance of Federal administration. When identifying errors in food stamp and SSI administration, agency and recipient actions are compared to Federal rules; in the AFDC and Medicaid systems, errors are identified through comparison with State operating policies, the State plan and Federal regulations.

The cost of operating quality control systems is carried as a regular administrative cost and, except for the SSI program, is shared by the States and Federal Government, just as any other administrative expense.

CORRECTIVE ACTION

The basic goal of quality control systems is to reduce, over time, the extent and cost of errors in program administration. As part of each system, "corrective action plans" for error reduction are regularly formulated based on the findings of the quality control sample surveys. Corrective actions can range from personnel policy changes or new computer systems, to substantive changes in eligibility rules or procedures for verifying information provided by recipients. Very often, "error-prone" profiles are drawn up from the results of quality control surveys to assist administrators in identifying cases to which particular attention should be paid.

SANCTIONS

Another use of the results of a quality control sample is to determine the degree to which States will be held financially liable for erroneous payments and underpayments.

In the AFDC and food stamp systems, States may be "sanctioned" by being required to pay the Federal Government the Federal cost of improperly issued benefits, as shown by quality control surveys, if they do not keep their error rates below the target rates. In calculating these sanctions, the degree to which States exceed targets for underpayment error rates is taken into account. While fiscal sanctions were included in legislation before the 1982 laws, they were waived when States demonstrated that they were making a good faith effort to reduce errors. When waivers were not granted, States appealed the decision to impose sanctions through administrative channels and the courts.

In April 1986, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, a 2-year moratorium was imposed on the collection of AFDC fiscal sanctions until July 1988, and the Family Support Act of 1988 (P.L. 100-485) extended it until July 1989. The act required the Department of Health and Human Services to conduct a study of the AFDC and Medicaid quality control systems for the purposes of restructuring the system as necessary during the moratorium period. The Department was also required to contract with the National Academy of Sciences to conduct an independent study. The National Academy of Sciences report was transmitted to Congress on February 23, 1988. In 1989, Congress revised the AFDC quality control system.

DESCRIPTION OF REVISED AFDC QC SYSTEM

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) authorized a new AFDC quality control system beginning for fiscal year 1991. The new system:

(1) Imposes penalties on States whose error rates are above the national average.

(2) Establishes penalties based on a sliding scale which reflect the degree to which a State's error rate exceeds the national average.

(3) Takes into account both overpayments and underpayments that are made to AFDC recipients, and gives States an incentive to improve their AFDC child support collection programs.

(4) Establishes a new Quality Control Review Panel to assure that quality control review cases that are in dispute between States and the Federal Government are resolved in a uniform and fair manner. The current Secretary's waiver procedure would no longer exist.

(5) Retains the Departmental Appeals Board to resolve all other issues in dispute between the States and the Federal Government.

Error measurement. The Secretary will use the same statistical methods to estimate errors as have been used under the old quality control system. Before the official error rate is determined, States may challenge the Federal review decisions by requesting reconsideration of any decisions on cases that are different from their own ("difference" cases) by a new Quality Control Review Panel to be established by the Secretary. Decisions by the Quality Control Review Panel will be on the record and will not be appealable to the Departmental Appeals Board. Decisions on difference cases may not be appealed to the court until and unless any disallowance becomes final. A disallowance becomes final if a State does not appeal the disallowance determination to the Departmental Appeals Board, or, if the State does appeal, once the Board has made a decision.

In establishing a State's error rate, certain types of errors will be excluded: (1) errors based on failure to carry out properly changes in Federal legislation for a period of 6 months after the effective date of the legislation or the issuance of interim final or final regulations, whichever is later (however, States would not be relieved of the obligations to implement new legislation); (2) errors resulting from a State agency's correct use of erroneous information received from Federal agencies; (3) errors resulting from a State agency's action based on written Federal policies (e.g., Federal written advisories made in response to State inquiries); (4) errors due to circumstances (defined as those resulting in a declaration of a state of emergency by the Governor or the President); and (5) errors due to monthly reporting that do not affect the amount of payment. The following errors are among those that would be counted: lack of a Social Security number in the file (unless an application for a number has been filed) and failure to assign child support rights.

The decision as to whether a case is in error will be made by comparison against permissible State practice (i.e., policies consistent with the approved State plan). However, if the State plan is inconsistent with Federal regulations, Federal regulations will prevail if the Secretary has informed the State of the inconsistency. If a change in State law is required, the Secretary may allow a reasonable time for the State to make the required change. A case which is at variance with Federal law and regulations because of compliance with a court order will be reviewed against the court order.

The Secretary, in consultation with the States, will establish regulations setting forth the time period in which reviews must be completed and findings must be reported; the time period in which difference cases must be resolved; the time period in which error rates must be issued; and the sample size necessary to obtain a statistically valid error rate. To enable the Department of HHS to meet these regulatory timetables, the Secretary must insure that there will be adequate staff to perform required functions, and shall report annually to the Senate Committee on Finance and the House Committee on Ways and Means as to whether the timetables have been met. If a State fails to complete its reviews on a timely basis, the Secretary may conduct the reviews on his own initiative and will charge the State for any costs incurred in making the reviews.

Determination of disallowances.—In general, the Federal Government will provide matching funds for all approvable State expenditures except for those in excess of the error tolerance level. The error tolerance level will be the national average error rate or 4 percent, whichever is higher, computed by determining the overpayment error rate for each State and determining the average for all States.

Disallowances for States with error rates above the error tolerance level will be assessed on a sliding scale, reflecting the degree to which the State's error rate exceeds the error tolerance level. For example, a State with an error rate of 7.8 percent is 20 percent above a 6.5 percent national average tolerance level and would owe 20 percent of the sanction on the entire amount of its overpayments above the tolerance level (20 percent × 1.3 percent × the Federal share of benefits). In no case, however, would a State be required to repay more than 100 percent of its overpayments above the tolerance level.

Any sanction amount owed by a State will be due upon issuance by the Secretary of the notice to the State of a disallowance. The State may pay immediately, or the Secretary and the State may negotiate an agreement under which repayment may be made over a period of up to 2½ years. Interest will accrue beginning 45 days after the date the State receives the notice of the disallowance. If a subsequent appeal is decided in the State's favor, the Federal Government will repay all State payments with interest.

Before repayment to the Federal Government, several adjustments shall be made.

(1) If a State's error rate for underpayments is below the national average, its repayment amount will be reduced by reducing its overpayment error rate. For example, if the underpayment rate is 0.1 percentage point below the national average, the overpayment error rate would be reduced by 0.1 percentage point. This reduction could be applied to any penalty due for the measurement year or for either of the following 2 years. The Secretary is required to conduct a study and report to Congress on negative case actions—improper denials and terminations.

(2) A State's repayment amount will also be reduced by a percentage equal to the percentage improvement in its AFDC child support collection rate (the number of AFDC cases for which a child support collection is made over the total number of AFDC cases) measured against the average collection rate for the State in the preceding 3 years, or the percentage by which the State's AFDC child support collection rate exceeds the national average, whichever is greater.

(3) The amount to be repaid will be further reduced to reflect overpayments recovered by the State.

Appeal procedures.—If a State decides to appeal its disallowance to the Departmental Appeals Board, it must do so within 60 days of the notice of disallowance. In deciding whether to uphold the disallowance or any portion of it, the conferees expect the Board to conduct a thorough review of the issues and to take into account all relevant evidence. With respect to difference cases, the Departmental Appeals Board will adopt the decision of the Quality Control Review Panel.

If an appeal is not completed by the Board within 90 days, interest will be suspended until the appeal is completed. A State may appeal a decision by the Departmental Appeals Board (including a decision adopted by the Board with respect to a difference case) to Federal district court within 90 days of the decision by the Board. Court review shall be on the record established in the Departmental Appeals Board review in accordance with the standard of review prescribed by section 706(2) (A) through (E) of title 5 of the United States Code.

Effective date; treatment of disallowances for prior years.—The new quality control system is effective beginning with fiscal year 1991. Disallowances imposed in 1992 will be based on error rates determined for 1991. All disallowances for error rates determined for years prior to 1991 were waived permanently.

HYPOTHETICAL EXAMPLE OF QUALITY CONTROL COMPUTATION

[Assumes: State overpayment rate: 8%, underpayment rate: 2.8%; National overpayment rate: 6%, underpayment rate: 3.0%]

1. Calculation of State error rate:	
a. National underpayment rate	3.0%
(less) State underpayment rate	2.8%
Underpayment "bonus"	0.2%
b. State overpayment rate	8.0%
(less) Underpayment "bonus"	0.2%
"Error rate"	7.8%
2. Calculation of "basic" disallowance:	
State's AFDC payments	$10,000,000
(times) Federal match rate	50%
Gross Federal Cost	$5,000,000
(times) Excess error rate (7.8% is 1.8 percentage points above 6% national average)	1.8%
Excess erroneous payment	$90,000
(times) Percent by which error rate exceeds national average. (7.8% is 30% above 6%)	30%
"Basic" disallowance	$27,000
3. Adjustment for overpayment recoveries:	
Overpayment recoveries (Federal share)	$5,000
(times) State error rate above national average (1.8%) as a percent of total State error rate (7.8%). (1.8% is 23% of 7.8%)	23%
Overpayment adjustment	$1,150
4. Adjustment for child support improvement:	
a. Percent by which AFDC child support collection rate (e.g. 16%) exceeds national AFDC child support collection rate (e.g. 12%). (16% is 33% higher than 12%)	33%
b. Percent by which AFDC child support collection rate (e.g. 16%) exceeds State average over 3 prior years (e.g. 14%). (16% is 14% higher than 14%)	14%
c. "Basic" disallowance from step 2	$27,000
(less) Overpayment adjustment (step 3)	$1,150
Adjusted disallowance	$25,850

HYPOTHETICAL EXAMPLE OF QUALITY CONTROL COMPUTATION—Continued

[Assumes: State overpayment rate: 8%, underpayment rate: 2.8%; National overpayment rate: 6%, underpayment rate: 3.0%]

(times) Child support adjustment percent (higher of 4.a. or 4.b.)	33%
Child support adjustment	$8,530
5. Final calculation:	
Adjusted disallowance (4.c.)	$25,850
(less) Child support adjustment	$8,530
Final disallowance amount	$17,320

QUALITY CONTROL STATISTICS

Table 1 depicts the estimated AFDC sanction amounts and estimated collection schedule according to the Department of Health and Human Services.

Table 2 summarizes national overpayment error rates for the four major welfare programs over recent quality control review periods. Table 3 shows the historical trend in the AFDC error rate beginning in 1973.

TABLE 1.—AFDC SANCTION AMOUNTS AND ESTIMATED COLLECTION SCHEDULE

Year errors were made	HHS estimated sanction amount (in millions)	HHS projected schedules for collecting sanctions
Fiscal year:		
1991	26.2	0
1992	27.5	0
1993	27.8	6.5
1994	27.8	20.0
1995	27.7	27.2
1996	27.6	27.7
Total	165	81.4

Source: Department of Health and Human Services.

TABLE 2.—SUMMARY OF NATIONAL OVERPAYMENT DOLLAR ERROR RATES BY PROGRAM

	AFDC	Medicaid [1]	Food stamps [2]	SSI
October 1979–March 1980	8.3	5.2	10.2	5.0
April 1980–September 1980	7.3	5.0	8.9	4.9
October 1980–March 1981	8.3	4.0	10.5	5.3
April 1981–September 1981	7.0	3.0	9.1	4.9

TABLE 2.—SUMMARY OF NATIONAL OVERPAYMENT DOLLAR ERROR RATES BY PROGRAM—Continued

	AFDC	Medicaid [1]	Food stamps [2]	SSI
October 1981–March 1982	7.2	2.7	9.9	4.8
April 1982–September 1982	6.6	[3] 2.9	9.2	4.1
October 1982–March 1983	6.2	[3] 2.6	8.2	4.1
April 1983–September 1983	6.8	[3] 2.9	8.5	3.6
October 1983–March 1984	6.2	[3] 2.5	[4] 8.6	[4] 3.3
April 1984–September 1984	5.7	[3] 2.9	[4] 8.6	[4] 3.3
Fiscal year 1985	6.1	[3] NA	8.3	3.3
Fiscal year 1986	7.1	[3] NA	8.1	3.9
Fiscal year 1987	6.3	[3] NA	7.6	3.8
Fiscal year 1988	6.8	[3] NA	7.4	3.5
Fiscal year 1989	5.7	[3] NA	7.3	3.4

[1] The error rates for the periods between October 1979 and March 1981 have been adjusted to reflect the new payment error rate definition implemented in April 1981.

[2] Source: U.S. Department of Agriculture, Food and Nutrition Serivce.

[3] The Medicare Catastrophic Coverage Act of 1988 (P.L. 100–360) retroactively modified the calculation of Medicaid error rates back to 1982. The Health Care Financing Administration (HCFA) has not as yet completed the recalculation of these error rates.

[4] The food stamps and SSI error rates are no longer calculated for a 6-month period, but for a fiscal year. These statistics are for fiscal year 1984.

NA.—Not available.

Note: Overpayment errors include payments made to ineligible families but do not include underpayments.

Source: Department of Health and Human Services and U.S. Department of Agriculture.

TABLE 3.—HISTORICAL TRENDS IN THE AFDC OVERPAYMENT DOLLAR ERROR RATE, 1973–89

Period	Percent	Period	Percent
April–September 1973	16.5	April–September 1980	7.3
January–June 1974	14.8	October 1980–March 1981	8.3
July–December 1974	13.6	April–September 1981	7.0
January–June 1975	12.0	October 1981–March 1982	7.2
July–December 1975	10.2	April–September 1982	6.6
January–June 1976	9.6	October 1982–March 1983	6.2
July–December 1976	8.5	April–September 1983	6.8
January–June 1977	8.6	October 1983–March 1984	6.2
July–December 1977	8.7	April–September 1984	5.7
January–June 1978	10.5	Fiscal year 1985	6.1
April–September 1978	9.4	Fiscal year 1986	7.1
October 1978–March 1979	10.4	Fiscal year 1987	6.3
April–September 1979	9.5	Fiscal year 1988	6.8
October 1979–March 1980	8.3	Fiscal year 1989	5.7

Source: Department of Health and Human Services, Office of Family Assistance.

HISTORICAL PERSPECTIVE OF QUALITY CONTROL IN THE AFDC PROGRAM

In the early 1960's, as AFDC costs and caseloads began to grow, Congress requested that the Department of Health, Education, and Welfare verify AFDC expenditures. In response to this request, the Department developed an on-going system to validate eligibility and benefits and to serve as a management tool to improve the accuracy of the eligibility and benefit determination process. This evolved into the current quality control system. Table 4 shows State payment errors over time.

In 1973, regulations were issued establishing error tolerance levels of 3 percent on errors resulting from ineligibility and 5 percent on under and overpayments. Any erroneous payments made by the State above these amounts would be disallowed. These tolerances, which were not established by statute, were challenged in court as being arbitrary and capricious by the State of Maryland (*Mathews* v. *Maryland*). The court ruled in Maryland's favor (1978).

On March 7, 1979, the Department issued new regulations establishing error rate limits based on the national average of error rates. The March 7 regulations also included a "good cause" provision enabling the Secretary to waive disallowances based on the State's failure to meet the limit. The March 7 regulation and the threat of disallowances were effective in getting States to implement corrective action. Disallowances were temporarily suspended if States submitted negotiated corrective action plans. No disallowances were taken.

In 1979 the Michel amendment was attached to the Labor, HHS and Education fiscal year 1980 appropriation bill. This amendment required each State to reach a payment error rate of 4 percent by September 30, 1983. In January 1980 the Department issued the following rules implementing the Michel requirements: States were required to make one-third progress toward the 4 percent goal in fiscal year 1981; two-thirds progress toward the goal in fiscal year 1982; and to attain 4 percent in fiscal year 1983.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) included further AFDC error rate reduction requirements. TEFRA requires States to move from the 4 percent standard established by the Michel amendment to a 3 percent standard in fiscal year 1984. The Consolidated Omnibus Budget Reconciliation Act of 1985 established a moratorium on the collection of fiscal sanctions. That moratorium expired on July 1, 1988, but was extended by the Family Support Act of 1988 until July 1, 1989.

Table 4 shows the State error rates for a base period and selected fiscal years from 1980 to 1989.

TABLE 4.—AFDC ERROR RATES FOR BASE PERIOD AND FISCAL YEARS 1980–89

	April–September 1978 [1]	1980	1985	1986	1987	1988	1989
U.S. average	9.4	7.8	6.1	7.1	6.3	6.8	5.7
Alabama	9.5	7.1	3.8	4.2	4.6	4.8	6.7
Alaska	31.2	13.9	10.5	5.5	2.8	4.1	4.3
Arizona	8.0	8.7	8.8	11.3	12.5	10.9	10.2
Arkansas	9.1	7.6	3.0	3.8	4.6	3.4	3.9
California	3.7	5.7	5.9	8.1	6.1	8.7	4.2
Colorado	4.3	11.6	5.5	3.3	1.8	2.8	3.1
Connecticut	8.6	6.3	4.7	4.0	3.3	5.5	4.0
Delaware	16.1	8.0	7.1	6.5	5.7	5.4	6.1
District of Columbia	22.4	12.5	9.9	10.0	8.9	7.7	5.6
Florida	5.6	6.1	5.7	9.0	8.8	10.9	8.0
Georgia	7.8	8.1	7.6	7.4	7.8	4.2	4.7
Hawaii	9.2	9.0	6.3	3.9	3.6	2.6	3.0
Idaho	4.4	9.0	3.9	4.0	6.2	3.7	3.9
Illinois	17.1	8.1	7.3	9.0	7.1	6.5	5.8
Indiana	1.7	4.5	4.7	5.4	6.2	5.0	4.7
Iowa	7.8	4.2	4.9	6.1	5.9	6.2	7.0
Kansas	4.1	5.8	5.1	4.3	5.8	4.1	5.3
Kentucky	10.2	5.4	3.2	3.0	3.4	3.2	3.1
Louisiana	11.1	6.8	7.2	4.8	6.2	8.0	7.2
Maine	9.2	6.6	5.7	4.4	3.9	5.2	5.2
Maryland	13.6	12.7	7.1	9.2	7.8	8.7	6.5
Massachusetts	15.9	12.5	3.6	3.3	4.6	6.3	4.9
Michigan	9.2	7.7	6.4	6.7	5.0	5.3	6.0
Minnesota	3.4	3.3	2.8	3.0	3.5	2.6	4.0
Mississippi	11.6	7.4	2.8	3.7	3.4	4.8	7.8
Missouri	10.1	7.3	3.9	3.6	3.2	4.4	3.7
Montana	9.7	10.2	7.5	5.7	7.1	4.7	2.8
Nebraska	4.6	4.9	7.9	7.5	7.9	5.6	8.0
Nevada	0.6	1.2	2.6	2.2	3.2	3.0	2.0
New Hampshire	11.0	11.0	5.2	5.0	4.8	4.6	5.3
New Jersey	9.3	10.4	6.3	7.5	9.3	7.3	7.0
New Mexico	4.8	7.3	5.7	5.9	7.1	7.0	7.4
New York	8.8	8.3	7.4	9.5	8.7	7.1	8.4
North Carolina	7.9	5.6	2.2	2.5	2.4	2.7	3.3
North Dakota	1.6	6.0	1.2	1.8	1.8	3.5	.9
Ohio	9.5	8.7	6.6	9.4	9.2	8.6	8.9
Oklahoma	3.2	4.4	2.8	3.9	3.8	4.4	5.2
Oregon	12.7	4.5	3.8	4.1	5.2	6.3	4.5
Pennsylvania	16.3	9.8	6.6	5.6	5.1	5.2	5.7

TABLE 4.—AFDC ERROR RATES FOR BASE PERIOD AND FISCAL YEARS 1980–89—Continued

	April–September 1978 [1]	1980	1985	1986	1987	1988	1989
Rhode Island	12.7	8.9	4.6	7.2	4.7	6.0	1.4
South Carolina	7.1	7.3	7.0	7.9	9.7	7.1	5.6
South Dakota	4.8	5.2	1.5	2.5	1.8	1.7	3.8
Tennessee	7.0	7.0	3.4	5.3	4.8	9.3	6.4
Texas	6.9	7.6	4.3	7.5	6.8	6.7	7.9
Utah	2.8	7.1	4.5	4.5	3.1	3.2	3.5
Vermont	4.5	11.4	5.7	7.1	6.8	12.0	2.4
Virginia	11.7	5.0	3.4	3.4	4.4	4.5	4.7
Washington	6.7	9.0	5.1	4.6	5.2	5.1	5.7
West Virginia	11.3	6.1	5.8	6.1	7.3	10.0	7.2
Wisconsin	11.1	7.9	8.6	6.3	4.8	4.5	4.9
Wyoming	4.0	13.8	3.0	4.0	3.9	3.5	3.5
Puerto Rico	7.8	7.6	6.3	5.7	6.1	4.9	6.1
Guam	NA	NA	14.2	11.5	12.8	13.3	NA
Virgin Islands	11.2	NA	4.2	4.4	3.0	2.2	NA

[1] Base period reflects the period that the first comprehensive, statistically valid State-specific rates were available.

Source: Department of Health and Human Services, Office of Family Assistance.

For fiscal years 1981 through 1986, disallowances summed to nearly $1.2 billion. Three States—California, Michigan, and New York—accounted for 51 percent of the disallowances. Also, 70 percent of the disallowances were in 1984, 1985, and 1986 when the more stringent 3 percent target error rate was in effect. Data on disallowances for fiscal years 1987 through 1990 are not available. Public Law 100-239 permanently waived the pre-1991 disallowances.

Tables 5 and 6 break down AFDC quality control error rates into various components. Table 5 shows that the major source of payment errors is from errors in reporting of income. Table 6 displays the proportion of errors coming from the agency versus the client. The national average splits almost equally between clients and the agencies.

Table 7 displays the disposition of applications for AFDC from 1974 through 1989. Since 1979, there has been a dramatic increase in the share of applications denied.

Table 8 summarizes the reasons for denial of AFDC benefits for the fourth quarter of fiscal year 1989. About 62 percent of the cases were denied because of "failure to comply with procedural requirements."

TABLE 5.—PERCENT DISTRIBUTION OF AFDC EXPENDITURES IN ERROR, BY MAJOR TYPE OF ERROR, FISCAL YEAR 1988 [1]

State	Major type of error				
	Basic program requirements [2]	Resources [3]	Income [4]	Need requirements [5]	Other
Total [6]	32.4	8.0	43.9	3.3	12.0
Alabama	24.0	7.5	57.7		10.8
Alaska	46.2		53.8		
Arizona	35.1	4.2	39.1	3.4	18.0
Arkansas	10.6	3.3	55.9		30.3
California	38.7	9.9	40.1	4.3	5.9
Colorado	34.9	3.9	60.6	0.6	
Connecticut	24.1	13.8	39.8		22.3
Delaware	24.0	7.9	62.1		6.0
District of Columbia	13.9	1.9	56.9	(7)	27.3
Florida	23.1	7.2	45.0	1.4	23.3
Georgia	19.7	7.0	67.3		5.9
Guam	47.6	1.8	38.8	2.8	8.9
Hawaii	15.4	21.1	35.8	3.2	24.5
Idaho	20.2		65.1	10.9	3.8
Illinois	16.7	4.9	59.0	(7)	19.3
Indiana	12.4	10.1	49.5		25.2
Iowa	19.0	13.6	47.1	1.2	19.1
Kansas	23.7	6.7	60.8	1.0	7.7
Kentucky	28.4	6.1	61.7	0.3	3.5
Louisiana	25.3	5.4	46.0		22.0
Maine	10.0	37.1	50.5		2.5
Maryland	35.6	6.3	46.0	0.6	11.5
Massachusetts	31.6	10.9	28.6	7.2	21.7
Michigan	43.8	0.9	36.0	11.8	7.6
Minnesota	41.3	15.0	37.9	0.4	1.5
Mississippi	28.7	9.3	54.6		7.4
Missouri	11.3	8.6	77.5		2.6
Montana	55.8		44.2		
Nebraska	4.4	8.5	44.3		42.9
Nevada	40.1	11.2	36.1		12.6
New Hampshire	43.9	3.7	42.6	7.8	2.1
New Jersey	18.2	6.5	54.0		20.4
New Mexico	28.3	12.1	53.1	0.8	5.7
New York	45.4	3.6	34.7	8.6	7.8
North Carolina	15.8	10.9	55.3		18.0

TABLE 5.—PERCENT DISTRIBUTION OF AFDC EXPENDITURES IN ERROR, BY MAJOR TYPE OF ERROR, FISCAL YEAR 1988 [1]—Continued

State	Major type of error				
	Basic program requirements [2]	Resources [3]	Income [4]	Need requirements [5]	Other
North Dakota	6.7	22.8	62.6	7.9	
Ohio	38.8	4.1	38.5	0.2	16.3
Oklahoma	28.3	4.6	50.4	4.7	11.3
Oregon	26.4	16.9	54.9	1.8	
Pennsylvania	26.6	11.0	52.5	0.1	9.8
Puerto Rico	21.5	12.9	44.3	10.2	10.8
Rhode Island	26.7	10.5	31.9		31.0
South Carolina	22.7	7.6	44.6		24.6
South Dakota			85.6	14.4	
Tennessee	18.4	7.4	51.7		22.5
Texas	14.6	12.7	58.9		13.7
Utah	35.3	18.6	39.5	1.3	5.4
Vermont	33.7	19.4	34.9	5.3	6.7
Virgin Islands	20.5	16.8	41.9		20.8
Virginia	31.5	2.1	43.5		22.9
Washington	36.7	16.5	42.1	0.8	4.0
West Virginia	30.0	16.5	42.4	1.9	9.3
Wisconsin	37.7	23.3	37.6	0.5	1.0
Wyoming	24.9	23.3	47.7		4.1

---

[1] Includes ineligible and eligible cases receiving incorrect payments.

[2] Basic program requirements: age, school attendance, living with a specified relative, deprivation (incapacity, continued absences, unemployment); WIN program registration, citizenship and alienage, residence, social security number, child support (assignment and cooperation), and monthly report.

[3] Resource items: real property; life insurance; bank deposits or cash on hand; motor vehicle; other.

[4] Income items: earned income, work incentive exemptions; mandatory deductions; work-related expenses; deemed income disregards; RSDI benefits; veterans benefits; unemployment compensation; workmen's compensation; support payment made to IV–D agency contributions; non-earned income disregards; deemed income.

[5] Need requirement items: shelter only, fuel and/or utilities only; basic budgetary allowance(s) other than shelter, fuel and utilities; shelter combined with fuel and/or utilities; shelter and other basic budgetary allowances (excluding fuel and utilities); all basic budgetary allowances (excluding fuel and utilities); all basic budgetary allowances; special diet; transportation; child care; other.

[6] Percentages are weighted by the proportion of each State's total payments to the national total.

[7] Less than 0.5 percent.

Source: Department of Health and Human Services, Family Support Administration, Office of Family Assistance.

TABLE 6.—AGENCY AND CLIENT ERROR CASES AS A PERCENT OF TOTAL AFDC ERROR CASES, FISCAL YEAR 1988 [1]

State	Total number of error cases	Percent of total error cases attributed to—		
		Agency	Client	Not reported
U.S. total [2]	7,555	57.7	41.8	0.5
Alabama	125	36.0	64.0	
Alaska	35	62.7	37.3	
Arizona	274	65.7	33.2	1.1
Arkansas	70	50.0	50.0	
California	253	59.7	39.9	.4
Colorado	55	47.2	52.8	
Connecticut	135	50.4	48.9	.7
Delaware	32	56.3	43.8	
District of Columbia	81	54.3	45.7	
Florida	484	56.0	43.8	.2
Georgia	121	45.5	54.5	
Guam	71	52.1	47.9	
Hawaii	37	67.6	32.4	
Idaho	42	71.4	28.6	
Illinois	322	51.4	48.6	
Indiana	146	47.3	50.0	2.7
Iowa	185	52.4	47.6	
Kansas	76	46.1	53.9	
Kentucky	139	46.8	53.2	
Louisiana	139	56.8	42.4	.7
Maine	57	56.1	43.9	
Maryland	360	49.2	50.8	
Massachusetts	155	61.3	37.4	1.3
Michigan	360	71.4	28.6	
Minnesota	148	67.6	29.1	3.4
Mississippi	110	62.7	37.3	
Missouri	209	51.2	48.3	.5
Montana	26	65.4	34.6	
Nebraska	61	77.0	23.0	
Nevada	25	76.0	24.0	
New Hampshire	70	65.7	34.3	
New Jersey	297	35.0	64.6	.3
New Mexico	68	52.9	45.6	1.5
New York	299	63.2	36.8	
North Carolina	116	61.2	38.8	
North Dakota	22	63.6	36.4	
Ohio	168	60.7	36.3	3.0
Oklahoma	95	58.9	35.8	5.3
Oregon	225	67.6	31.6	.9
Pennsylvania	116	58.6	41.4	
Puerto Rico	183	47.5	50.8	1.6
Rhode Island	35	71.4	28.6	
South Carolina	349	69.1	30.1	.8

TABLE 6.—AGENCY AND CLIENT ERROR CASES AS A PERCENT OF TOTAL AFDC ERROR CASES, FISCAL YEAR 1988 [1]—Continued

State	Total number of error cases	Percent of total error cases attributed to—		
		Agency	Client	Not reported
South Dakota	22	59.1	40.9	....
Tennessee	145	56.6	43.4	....
Texas	125	41.7	58.3	....
Utah	47	61.7	38.3	....
Vermont	52	46.2	53.8	....
Virgin Islands	17	35.3	58.8	5.9
Virginia	158	62.0	37.3	.6
Washington	226	38.3	61.7	....
West Virginia	149	49.7	49.7	.7
Wisconsin	209	53.8	45.2	1.0
Wyoming	29	69.0	27.6	3.4

---

[1] Includes ineligible and eligible cases receiving incorrect payments.

[2] Percentages weighted by the proportion of each State's average caseload to the national average.

Source: Office of Family Assistance, Family Support Administration.

TABLE 7.—SUMMARY OF DISPOSITION OF APPLICATIONS FOR AFDC, FISCAL YEARS 1974–89

Fiscal year	Total dispositions [1] (thousands)	Approved (percent)	Denied (percent)	Other disposition [2] (percent)
1974	2,129	68.2	19.5	12.3
1975	2,537	67.0	20.6	12.4
1976	2,513	66.2	20.6	13.2
1977	2,589	66.4	20.0	13.7
1978	2,577	66.1	20.2	13.7
1979	2,622	66.4	20.5	13.1
1980	2,923	65.2	22.8	12.0
1981	3,006	65.6	23.2	11.2
1982	3,045	64.2	25.4	10.4
1983	3,181	64.1	25.6	10.4
1984	3,106	65.5	24.7	9.8
1985	3,217	64.4	25.5	10.1
1986	3,347	63.0	26.9	10.1
1987	3,380	62.8	27.5	9.7
1988	3,438	64.2	27.1	10.0
1989	3,621	63.8	41.0	25.5

[1] Does not include data for Guam in some years before 1980, or 1980–84 data for Alaska.

[2] Most of the "other" dispositions represent withdrawn applications, and some were from applicants who moved or could not be located. For a small number the reason for disposition was not specified.

Source: Fiscal year 1974–76, Quarterly A–12 reports of the National Center for Social Statistics, U.S. Department of Health, Education and Welfare. Fiscal year 1977–86, Table G, p. 91, Quarterly Public Assistance Statistics; Fiscal years 1986 through 1989, Family Support Administration, U.S. Department of Health and Human Services.

TABLE 8.—DISPOSITION OF AFDC APPLICATIONS, BY STATE, JULY 1–SEPTEMBER 30, 1989

	Total	Accepted	Denied	Denied, by reason			Otherwise
				Failure to comply with procedural requirements	Income or resources exceed limits	Other	
Total	960,954	64.0	25.7	15.9	6.2	3.6	10.3
Alabama	7,159	59.6	31.6	20.1	9.1	2.4	8.8
Alaska	2,675	62.7	30.2	3.3	15.3	11.6	7.1
Arizona	15,545	51.3	36.5	22.5	8.4	5.6	12.2
Arkansas	9,057	50.6	39.9	25.8	9.8	4.3	9.5
California	125,037	54.7	24.3	15.7	4.3	4.3	21.0
Colorado	12,453	69.3	26.8	20.0	5.5	1.3	3.8
Connecticut	7,133	49.7	34.0	29.4	2.6	2.0	16.3
Delaware	1,632	71.9	23.6	12.6	8.2	2.8	4.5
District of Columbia	3,799	59.3	36.9	9.4	17.7	9.8	3.8
Florida	38,471	59.6	34.9	29.8	3.4	1.7	5.5
Georgia	36,432	43.9	45.4	30.6	9.3	5.5	10.7
Guam	203	88.2	11.8	4.9	6.4	.5	0
Hawaii	3,407	59.7	26.4	7.8	10.5	8.0	14.0
Idaho	3,504	51.7	29.9	14.2	11.8	3.9	18.4
Illinois	38,691	68.3	26.5	23.2	1.6	1.7	5.2
Indiana	11,696	72.0	19.9	10.6	7.1	2.2	8.0
Iowa	11,914	68.8	26.5	13.8	8.4	4.3	4.7
Kansas	11,822	89.2	9.2	3.4	5.3	.5	1.6
Kentucky	16,522	73.8	22.8	15.8	3.8	3.2	3.4

Louisiana	21,744	55.2	27.1	13.8	8.9	4.3	17.8
Maine	4,469	68.9	26.9	11.6	10.6	4.7	4.2
Maryland	15,471	63.6	27.2	19.6	5.0	2.6	9.2
Massachusetts	15,875	73.8	21.4	15.7	2.7	3.0	4.8
Michigan	55,372	64.0	31.0	18.3	9.3	3.3	5.0
Minnesota	17,507	86.0	10.2	6.0	3.4	.9	3.7
Mississippi	11,893	59.2	32.5	13.2	9.6	9.7	8.3
Missouri	21,585	67.6	20.1	5.9	13.4	0.7	12.3
Montana	2,794	95.8	3.4	1.5	.6	1.3	.7
Nebraska	2,700	80.4	11.7	3.3	5.4	3.0	7.9
Nevada	4,517	38.6	55.1	30.4	21.7	3.0	6.3
New Hampshire	2,511	56.8	33.0	18.3	8.2	6.5	10.2
New Jersey	22,881	86.4	10.5	0	6.4	4.1	3.1
New Mexico	4,829	55.2	39.9	15.5	13.4	10.9	4.9
New York	76,253	75.8	4.6	3.1	1.4	.1	19.6
North Carolina	23,416	79.1	9.9	2.7	3.2	4.0	11.1
North Dakota	1,326	78.4	17.7	4.4	9.1	4.2	3.9
Ohio	35,241	67.3	22.1	10.2	9.1	2.8	10.6
Oklahoma	15,889	62.0	24.7	11.1	8.7	5.0	13.3
Oregon	7,271	82.3	14.4	8.5	3.3	2.6	3.3
Pennsylvania	34,415	76.7	10.0	5.7	3.9	.4	13.4
Puerto Rico	5,901	69.3	25.2	16.9	5.5	2.7	5.5
Rhode Island	2,565	71.6	17.3	11.2	5.0	1.2	11.0
South Carolina	12,992	49.3	42.4	22.3	5.6	14.5	8.3
South Dakota	2,923	85.2	11.5	1.6	3.9	5.9	3.3
Tennessee	18,756	65.4	23.8	10.3	9.4	4.1	10.7

TABLE 8.—DISPOSITION OF AFDC APPLICATIONS, BY STATE, JULY 1–SEPTEMBER 30, 1989—Continued

	Total	Accepted	Denied	Denied, by reason			Otherwise
				Failure to comply with procedural requirements	Income or resources exceed limits	Other	
Texas	82,520	45.4	49.8	36.7	7.9	5.2	4.7
Utah	5,761	64.0	29.2	12.5	10.9	5.8	6.8
Vermont	2,925	56.6	30.3	11.1	8.9	10.3	13.1
Virgin Islands	120	77.5	11.7	5.8	1.7	4.2	10.8
Virginia	13,327	62.4	29.2	18.6	6.2	4.4	8.4
Washington	20,230	62.4	28.3	21.1	5.7	1.5	9.4
West Virginia	10,592	70.9	21.5	13.1	7.0	1.4	7.6
Wisconsin	24,774	83.8	15.6	0	7.3	8.2	.6
Wyoming	2,457	70.9	27.8	19.0	7.9	.8	1.3

Source: U.S. Department of Health and Human Services.

APPENDIX O. DESCRIPTION OF OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS NOT WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

Several Federal programs outside of the jurisdiction of the Committee on Ways and Means provide benefits to some share of those people who also benefit from assistance programs that are within the jurisdiction of the committee. This appendix describes several such programs: food stamps; Medicaid; housing assistance; school lunch and breakfast programs; the supplemental food program for Women, Infants, and Children (WIC); assistance provided under the Job Training Partnership Act; Head Start; the Low-Income Home Energy Assistance Program (LIHEAP); and Veterans' Benefits and Services Programs.

Most families receiving AFDC would have incomes low enough to qualify them—or particular members of those families—for assistance under these programs. Unlike the principal assistance programs under the jurisdiction of the Committee on Ways and Means, participation in Medicaid, food stamps, and veterans' benefits programs is limited either by appropriations, or, in the case of the school feeding programs, by the willingness of schools to participate. Income received from AFDC is counted in determining eligibility for these programs—as well as benefit levels, in some cases. However, because these programs provide in-kind rather than cash assistance, benefits received under these programs are not counted in determining eligibility for AFDC.

Tables 1 and 2 describe the overlap in recipients between programs within the jurisdiction of the Committee on Ways and Means and other major Federal assistance programs. Table 1 illustrates that 82.7 percent of AFDC recipient households received food stamps some time during the first quarter of 1990; 18.7 percent received WIC; 97.6 percent received Medicaid, 52.7 percent received free or reduced-price school meals; and 34.7 percent received housing assistance of some form.

Table 2 illustrates the reverse. For example, 50.4 percent of food stamp households received AFDC benefits at some time during the first quarter of 1990; 22.2 percent of food stamp households received SSI; and 2.1 percent of food stamp households received unemployment compensation benefits.

TABLE 1.—PERCENT OF RECIPIENTS IN PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS RECEIVING ASSISTANCE FROM OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS

[Households, first quarter of 1990]

	AFDC	SSI	Social Security	Unemployment compensation	Medicare
Number of households receiving benefits (in thousands)	3,434	3,037	26,098	1,716	23,144
Percent receiving:					
Food stamps	82.7	41.3	6.3	6.9	5.3
WIC	18.7	3.0	0.7	3.8	0.4
Free or reduced-price school meals	52.7	15.3	3.3	13.9	1.9
Public or subsidized rental housing	34.7	21.4	7.5	5.2	7.6
Medicaid	97.6	99.7	12.0	6.8	11.5
VA compensation or pensions	1.3	5.7	6.0	2.6	6.0

Note: Table reads that 82.7 percent of AFDC households, also receive food stamps.

Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

TABLE 2.—PERCENT OF RECIPIENTS IN OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS RECEIVING ASSISTANCE UNDER PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

[Households, first quarter of 1990]

	Food stamps	WIC	Free or reduced school meals	Public or subsidized rental housing	Medicaid	VA compensation or pensions
Number of households receiving benefits (in thousands)	5,637	1,697	6,702	4,877	7,931	2,613
Percent receiving:						
AFDC	50.4	37.8	27.0	24.4	42.3	1.7
SSI	22.2	5.3	6.9	13.3	38.2	6.6
Social Security	29.0	11.4	13.0	39.9	39.5	59.7
Unemployment compensation	2.1	3.8	3.6	1.8	1.5	1.7
Medicare	21.6	5.1	6.5	36.0	33.6	53.0

Note: Table reads that 50.4 percent of food stamp recipient households receive AFDC.

Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

FOOD STAMP PROGRAM

Food stamps are designed primarily to increase the food purchasing power of eligible low-income households to a point where they can buy a nutritionally adequate low-cost diet. Participating households are expected to be able to devote 30 percent of their counted monthly cash income to food purchases.[1] Food stamp benefits then make up the difference between the household's expected contribution to its food costs and an amount judged to be sufficient to buy an adequate low-cost diet. This amount, the maximum food stamp benefit level, is derived from the U.S. Department of Agriculture's lowest-cost food plan (the Thrifty Food Plan), varied by household size, and adjusted annually for inflation. Thus, a participating household with no counted cash income receives the maximum monthly allotment for its household size, intended to enable it to purchase an adequate low-cost diet with its food stamps alone, while one with some counted income receives a lesser allotment, reduced from the maximum at the rate of 30 cents for each dollar of counted income and intended to enable it to purchase an adequate low-cost diet with a combination of food stamps and its own cash.

Benefits are available to nearly all households that meet Federal eligibility tests for limited monthly income and liquid assets, as long as certain household members fulfill work registration and employment and training program requirements. In addition, recipients in the two primary Federal/State cash welfare programs, the AFDC and SSI programs, generally are automatically eligible for food stamps; households composed entirely of ADFC or SSI recipients are categorically eligible for food stamp aid, without regard to food stamp income and assets standards.[2]

ADMINISTRATION, PROGRAM VARIATIONS, AND FUNDING

The regular Food Stamp program operates in all 50 States, the District of Columbia, Guam, and the Virgin Islands. The Federal Government is responsible for virtually all of the rules that govern the program and, with limited variations for Alaska, Hawaii, and the territories, these rules are nationally uniform. States, the District of Columbia, and the territories may choose to offer the program or not. However, if they do offer food stamp assistance, it must be made available throughout the jurisdiction and comply with Federal rules. Sales taxes on food stamp purchases may not be charged.

Alternative programs are offered in Puerto Rico and the Northern Mariana Islands, and program variations occur in a number of demonstration projects and in those jurisdictions that have elected to exercise the limited number of program options allowed.

Funding is overwhelmingly Federal, although the States and other jurisdictions have financial responsibility for significant administrative costs, as well as liability for erroneous benefit determinations (as assessed under the food stamp "quality control" system).

---

[1] Because not all of a household's income is actually counted when determining its food stamp benefits, the program, in effect, assumes that most participants are able to spend about 20 percent of their total cash monthly income on food.

[2] Except for SSI recipients in California and Wisconsin, where a State-financed adjustment to SSI benefits has replaced food stamp assistance.

Federal administrative responsibilities

At the Federal level, the program is administered by the Agriculture Department's Food and Nutrition Service (FNS). The FNS gives direction to welfare agencies through Federal regulations that define eligibility requirements, benefit levels, and administrative rules. It is also responsible for (1) printing food stamp coupons and distributing them to welfare agencies and (2) approving, and overseeing participation by, retail food stores and other outlets that may accept food stamps. Other Federal agencies that have administrative roles to play include: the Federal Reserve System (through which food stamps are redeemed for cash), the Social Security Administration (responsible for the social security numbers recipients must have, provision of limited application "intake" services, and providing information to verify recipients' income), the Internal Revenue Service (providing assistance in verifying recipients' income and assets), and the Immigration and Naturalization Service (helping welfare offices confirm alien applicants' status).

State and local administrative responsibilities

States, the District of Columbia, Guam, and the Virgin Islands, through their local welfare offices, have primary responsibility for the day-to-day administration of the Food Stamp program. They determine eligibility, calculate benefits, and issue food stamp allotments following Federal rules. They also have a significant say about carrying out employment and training programs and some administrative features of the program (e.g., the extent to which verification of household circumstances is pursued, the method by which food stamps are issued). Most often, the Food Stamp program is operated through the same welfare agency and staff that runs the Federal/State AFDC and Medicaid programs.

Puerto Rico and the Northern Mariana Islands

In addition to the regular Food Stamp program, the Food Stamp Act directs funding for a nutrition assistance program in the Commonwealth of Puerto Rico. Separate legislation authorizes a variant of the Food Stamp program in the Commonwealth of the Northern Mariana Islands.

Since July 1982, Puerto Rico has operated a nutrition assistance program of its own design, funded by an annual Federal "block grant." [3] The Commonwealth's nutrition assistance program differs from the regular Food Stamp program primarily in that: (1) funding is limited to an annual amount specified by law; [4] (2) the Food Stamp Act allows the Commonwealth a great deal of flexibility in program design, as opposed to the regular program's extensive Federal rules; (3) benefits are paid in cash (checks) rather than food stamp coupons; (4) income and liquid assets eligibility limits are about half those used in the regular Food Stamp program; (5) maximum benefit levels are about one-quarter less than in the 48 contiguous States and the District of Columbia; and (6) different rules are used in counting income for eligibility and benefit purposes. In fiscal year 1990, Puerto Rico's nutrition assistance program aided approximately 1.5 million persons each month with monthly benefits averaging $51 a person.

---

[3] Prior to July 1982, the regular Food Stamp program operated in Puerto Rico, although with slightly different eligibility and benefit rules.

[4] For fiscal year 1991, $974 million is earmarked, including $10.8 million for a cattle tick eradication program. The block grant funds the full cost of benefits, plus half the cost of administration.

Under the terms of the 1976 Covenant with the Commonwealth of the Northern Mariana Islands and implementing legislation (P.L. 96-597), a variant of the Food Stamp program was negotiated with the Commonwealth and began operations in July 1982. The program in the Northern Marianas differs primarily in that: (1) it is funded entirely by Federal money, up to a maximum grant of $3.7 million a year; (2) a portion of each household's food stamp benefit must be used to purchase locally produced food; (3) maximum allotments are about 20 percent higher than in the 48 contiguous States and the District of Columbia; and (4) income eligibility limits are about half those in the regular program. In fiscal year 1990, the Northern Marianas' program assisted some 4,000 people each month with monthly benefits averaging $66 a person.

Program options

The Food Stamp Act authorizes demonstration projects to test program variations that might improve operations.[5] In addition, States are allowed to implement a few optional aspects of the Food Stamp program. States may require "monthly reporting" and "retrospective budgeting" for parts of their food stamp caseload. They may disregard the first $50 a month in child support payments, if they pay the benefit cost of doing so. States or localities may choose to run "workfare" programs, and State welfare agencies exercise primary responsibility in the design of food stamp employment and training programs. And States can operate "outreach" programs, with Federal cost-sharing, to inform low-income persons about food stamps.

Funding

The Food Stamp Act provides 100 percent Federal funding of food stamp benefits. The Federal Government is also responsible for its own administrative costs: overseeing program operations (including oversight of participating food establishments), printing and distributing food stamp coupons to welfare agencies, redeeming food stamp coupons through the Federal Reserve, and payments to the Social Security Administration for certain intake services.

Welfare agency administrative costs are shared by the Federal Government to varying degrees. Basic day-to-day administrative costs are shared equally with the States.[6] The cost of optional outreach activities is also eligible for a 50-percent Federal match. Costs associated with the development of computer capability and fraud control activities are eligible for a 75-percent Federal share, and welfare agencies are allowed to retain a portion of overissued benefits they collect. Costs for implementing the Systematic Alien Verification for Entitlements (SAVE) program are fully reimbursed by the Federal Government. And the cost of carrying out food stamp employment and training programs is shared by the Federal Government in two ways: (1) each State or other jurisdiction receives a Federal grant for basic operating costs (a formula share of $75 million); (2) additional employment and training program operating costs, as well as expenses for support services to participants (e.g., transportation and child care), are eligible for a 50-percent Federal matching share.[7]

---

[5] At present, four types of demonstration projects are underway: (1) "cashout" project for the elderly and SSI recipients, (2) "electronic benefit transfer" projects testing alternative methods of benefit delivery, (3) projects providing cash benefits to very poor households eligible for expedited service, (4) projects testing simplified AFDC/FS application and benefit determination procedures, and (4) "welfare reform" demonstrations testing various combinations of standardized AFDC/FS rules, cashing out food stamp benefits, and merging food stamp and AFDC rules and benefits.

[6] This 50-percent Federal share can be increased to as much as 60 percent where the State has a very low rate of erroneous benefit determinations.

TABLE 3.—RECENT FOOD STAMP EXPENDITURES

[In millions of dollars]

Fiscal year	Benefits [2] (Federal)	Administration [1]		Total
		Federal	State and local	
1979	6,480	515	388	7,383
1980	8,685	503	375	9,563
1981	10,630	678	504	11,812
1982	10,408	709	557	11,674
1983	11,955	778	612	13,345
1984	11,499	971	805	13,275
1985	11,556	1,043	871	13,470
1986	11,415	1,113	935	13,463
1987	11,344	1,195	996	13,535
1988	11,999	1,290	1,080	14,369
1989	12,483	1,332	1,101	14,916
1990 (estimated)	15,094	1,423	1,185	17,702

[1] All Federal administrative costs associated with the Food Stamp program and Puerto Rico's block grant are included: Federal matching for the various administrative and employment and training expenses of States and other jurisdictions (including Puerto Rico), and direct Federal administrative costs. Figures for Federal administrative costs beginning with fiscal year 1989 include only those paid out of food stamp appropriation and the food stamp portion of the general appropriation for food program administration. Figures for earlier years include estimates of food stamp related Federal administrative expenses paid out of other Agriculture Department accounts.

State and local costs are estimated based on the known Federal shares and represent an estimate of all administrative expenses of participating States and other jurisdictions (including Puerto Rico).

[2] All benefit costs associated with the Food Stamp program and Puerto Rico's block grant are included. The benefit amounts shown in the table reflect small downward adjustments for overpayments collected from recipients and, beginning in 1989, issued but unredeemed benefits. Over time, the figures reflect both changes in benefit levels and numbers of recipients.

Source: Budget documents prepared by the FNS. Compiled by the Congressional Research Service.

---

[7] The Federal 50-percent share for support services is limited. Coverage extends to (1) dependent care costs up to $160 per dependent per month and (2) other expenses (e.g., transportation) up to $25 per participant per month.

ELIGIBILITY

The Food Stamp program has financial, employment/training-related, and "categorical" tests for eligibility. Its financial tests require that most of those eligible have monthly income and liquid assets below limits set by food stamp law. Under the employment/training-related tests, certain household members must register for work, accept suitable job offers, and fulfill work or training requirements (such as looking or training for a job) established by State welfare agencies. The limited number of categorical eligibility rules make some automatically eligible for food stamps (most AFDC and SSI recipients), and categorically deny eligibility to others (e.g., strikers, illegal and temporarily resident aliens, those living in institutional settings). Applications cannot be denied because of the length of a household's residence in a welfare agency's jurisdiction or because it has no fixed mailing address or does not reside in a permanent dwelling.

The food stamp household

Generally speaking, individuals living together and purchasing food and preparing meals in common constitute the basic food stamp beneficiary unit: the food stamp "household." Individuals who are members of the same food stamp household must apply together, and the income, expenses, and assets of all members are aggregated in determining the household's eligibility and monthly benefit allotment. Most often, persons living together receive larger aggregate benefits if they are treated as more than one food stamp household.

Individuals and family units who live together may, in some cases, apply as *separate* food stamp households, have only their income, expenses, and assets taken in account, and receive a benefit in their own right. Related and unrelated persons are treated differently in this respect, as are the elderly and disabled and those living in certain group living arrangements:

—Unrelated persons who purchase food and prepare meals separate from their co-residents may apply separately.

—Relatives (i.e., parents, children, brothers, and sisters) generally must apply together, regardless of the above-noted "purchase and prepare" rule. Children under the parental care of an adult usually must apply together with their parent(s) or caretaker(s). *But* parents with their minor children, as well as elderly or disabled individuals (and their spouses), are exempt from this requirement and may, as with unrelated persons, apply separately if they purchase food and prepare meals separate from their co-residents.[8]

—Elderly persons living with relatives (e.g., their adult children) who *cannot* purchase food and prepare meals separately because of a substantial disability may apply separately, as long as those they live with have a monthly income below prescribed limits.

---

[8] In the Food Stamp program, "elderly" persons are those age 60 or older. The "disabled" generally are beneficiaries of governmental disability-based assistance (e.g., social security or SSI disability recipients, disabled veterans, certain disability retirement annuitants, recipients of disability-based Medicaid or general assistance).

—Individuals living in approved treatment programs for drug addicts or alcoholics, certain small group homes for the disabled, shelters for battered women and children, and shelters for the homeless are treated as separate households for food stamp purposes, without regard to the purchase and prepare rule.

—Persons with foster children in their care may choose to apply separately from the foster child.

As a result, different food stamp households can live together, food stamp recipients can reside with nonrecipients, and food stamp households themselves may be "mixed," including recipients and nonrecipients of other welfare benefits (the food stamp household unit is unrelated to other aid programs' basic recipient units, such as families with children in the AFDC program, and single persons and couples in the SSI program).

Income eligibility

Except for households composed entirely of AFDC or SSI recipients (who generally are automatically eligible for food stamps), *monthly cash income* is the primary food stamp eligibility determinant.[9]

In establishing eligibility for households *without an elderly or disabled member,* the Food Stamp program uses both the household's *basic* (or "gross") monthly income and its *counted* (or "net") monthly income.

When judging eligibility for households *with elderly or disabled members,* only the household's *counted* monthly income is considered; in effect, this applies a more liberal income test to elderly and disabled households.

Basic (or gross) monthly income includes all of a household's *cash* income, only excepting the following "exclusions" (disregards): (1) payments made to third parties (rather than directly to the household;[10] (2) unanticipated, irregular, or infrequent income, up to $30 a quarter; (3) loans (deferred repayment student loans are treated as student aid, see below); (4) income received for the care of someone outside the household; (5) nonrecurring lump-sum payments such as income tax refunds and retroactive lump-sum social security payments (these are instead counted as liquid assets); (6) energy assistance; (7) expense reimbursements that are not a "gain or benefit" to the household; (8) income earned by schoolchildren; (9) the cost of producing self-employment income; (10) postsecondary student aid (e.g., Pell grants, student loans) to the extent that it is used or earmarked for tuition, mandatory school fees or expenses, loan origination fees, and miscellaneous education-related expenses; (11) payments of earned income tax credits; (12) "on-the-job" training earnings of dependent children under 19 in Job Training Partnership Act (JTPA) programs, as well as JPTA monthly "allowances;" and (13) payments required to be disregarded by provisions of Federal law outside the Food Stamp Act (e.g., various payments under laws relating to Indians, payments under the Older Americans Act employment program for the elderly).

---

[9] Although they do not have to meet food stamp income and assets tests, AFDC and SSI households must still have their income calculated under food stamp rules to determine their food stamp *benefits.*

[10] Some third-party ("vendor") payments for normal living expenses are *not* disregarded.

Counted (or net) monthly income is computed by subtracting certain "deductions" from a household's basic (or gross) monthly income. It recognizes that not all of a household's income is equally available for food purchases by disregarding a standard portion of income, plus amounts representing work expenses or excessively high non-food living expenses.

For households *without an elderly or disabled member,* counted monthly income equals their basic (gross) monthly income less the following deductions:

—an inflation-indexed (each October) "standard deduction" set at $116 a month in fiscal year 1991, regardless of household size; [11]

—20 percent of any earned income, in recognition of taxes and work expenses;

—out-of-pocket dependent care expenses, when related to work or training, up to $160 a month for each dependent; and

—any shelter expenses, to the extent they *exceed* 50 percent of counted income after all other deductions, up to an inflation-indexed (each October) ceiling set at $186 a month in fiscal year 1991.[12]

TABLE 4.—FOOD STAMP DEDUCTION LEVELS

[Effective October 1990 through September 1991]

	48 States and D.C.	Alaska	Hawaii	Guam	Virgin Islands
Monthly standard deduction [1]	$116	$199	$165	$233	$103
Monthly ceiling on shelter expense deductions [2]	186	323	265	225	137
Monthly ceiling on dependent care deductions [3]	160	160	160	160	160
Monthly threshold for medical expense deductions [4]	35	35	35	35	35

[1] Indexed annually (and rounded down to the nearest whole dollar), each October, to reflect changes (through the immediately previous June) in the Consumer Price Index for All Urban Consumers (CPI-U), for items other than food. Not varied by household size or type.

[2] Indexed annually (and rounded down to the nearest whole dollar), each October, to reflect changes (through the immediately previous June) in the shelter, fuel, and utilities components of the CPI-U. Not applied to households with elderly or disabled members.

[3] Not indexed. Maximum deduction per dependent.

[4] Not indexed. Medical expense deductions available only to the elderly and disabled.

For households *with an elderly or disabled member,* counted monthly income equals their basic (gross) monthly income less the following deductions:

—the same standard, earned income, and dependent care deductions noted above;

---

[11] Different standard deductions prevail for Alaska, Hawaii, and the territories.

[12] Different ceilings prevail in Alaska, Hawaii, and the territories.

—any shelter expenses, to the extent they exceed 50 percent of counted income after all other deductions, *with no limit;* and

—any out-of-pocket medical expenses (other than those for special diets) that are incurred by an elderly or disabled household member, to the extent they exceed a "threshold" of $35 a month.

Except for those households comprised entirely of AFDC or SSI recipients, in which case food stamp eligibility generally is automatic, all households must have counted (net) monthly income that does not exceed the Federal poverty guidelines, as adjusted for inflation each October. Households without an elderly or disabled member also must have basic (gross) monthly income that does not exceed 130 percent of the inflation-adjusted Federal poverty guidelines. Both these income eligibility limits are uniform for the 48 contiguous States, the District of Columbia, Guam, and the Virgin Islands; somewhat higher limits (based on higher poverty guidelines) are applied in Alaska and Hawaii.

TABLE 5.—COUNTED (NET) AND BASIC (GROSS) MONTHLY INCOME ELIGIBILITY LIMITS

[Effective October 1990 through September 1991]

Household size	48 States, D.C., and the territories	Alaska	Hawaii
COUNTED (NET) MONTHLY INCOME ELIGIBILITY LIMITS[1]			
1 person	$524	$654	$603
2 persons	702	877	808
3 persons	880	1,100	1,013
4 persons	1,059	1,324	1,218
5 persons	1,237	1,547	1,423
6 persons	1,415	1,770	1,628
7 persons	1,594	1,994	1,833
8 persons	1,772	2,217	2,038
Each additional person	+179	+224	+205
BASIC (GROSS) MONTHLY INCOME ELIGIBILITY LIMITS[2]			
1 person	$681	$850	$784
2 persons	913	1,140	1,050
3 persons	1,144	1,430	1,317
4 persons	1,376	1,721	1,583
5 persons	1,608	2,011	1,850
6 persons	1,840	2,301	2,116
7 persons	2,072	2,592	2,383
8 persons	2,304	2,882	2,649
Each additional person	+232	+291	+267

[1] Set at the applicable Federal poverty guidelines, updated for inflation through calendar 1989.

[2] Set at 130 percent of the applicable Federal poverty guidelines, updated for inflation through calendar 1989.

Allowable assets

Except for those households who are automatically eligible for food stamps because they are composed entirely of AFDC or SSI recipients, eligible households must have *counted "liquid" assets* that do not exceed federally prescribed limits. Households without an elderly member cannot have counted liquid assets above $2,000. Households with an elderly member cannot have counted liquid assets above $3,000.

Counted liquid assets include cash on hand, checking and savings accounts, savings certificates, stocks and bonds, individual retirement accounts (IRAs) and "Keogh" plans (less any early withdrawal penalties), and non-recurring lump-sum payments such as insurance settlements. Certain "less liquid" assets are also counted: a portion of the value of vehicles (generally, the "fair market value" in excess of $4,500) and the equity value of property not producing income consistent with its value (e.g., recreational property).

Counted assets *do not include* the value of the household's residence (home and surrounding property), business assets, personal property (household goods and personal effects), burial plots, the cash value of life insurance policies and pension plans (other than Keogh plans and IRAs), and certain other resources whose value is not accessible to the household or are required to be disregarded by other Federal laws.

Work registration and employment and training program requirements

Unless exempt, adult applicants for food stamps must register for work, typically with the welfare agency or a State employment service office. To maintain eligibility, they must accept a suitable job if offered one and fulfill any work, "job search," or training requirements established by administering welfare agencies. If the household head fails to fulfill any of these requirements, the entire household is disqualified, typically for 2 months; in other cases, failure to comply disqualifies the non-complying household member only.

Those who are *exempt by law* from work registration, having to accept a suitable job offer, and employment and training program requirements (work, job search, training) include: persons physically or mentally unfit for work, those under age 16 or age 60 or older, and individuals between 16 and 18 (if they are not head of household or are attending school or a training program); persons working at least 30 hours a week or earning the minimum wage equivalent; persons caring for dependents who are disabled or under age 6, and those caring for children between ages 6 and 12 if adequate child care is not available (this second exemption is limited to allowing these persons to refuse a job offer if care is not available); individuals already subject to and complying with another assistance program's work, training, or job search requirements (i.e., those in AFDC work, training, or job search programs or fulfilling unemployment compensation job search requirements); otherwise eligible postsecondary students; and residents of drug addiction and alcoholic treatment programs.

Those not exempted by one of the above-listed rules must, at least, register for work and accept suitable job offers. However, the main thrust of the food stamp employment and training program is to ensure that non-exempt recipients ("mandatory" work registrants) also fulfill some type of work, job search, or training obligation. To carry this out, welfare agencies are required to operate an employment and training program of their own design for work registrants whom they designate. Welfare agencies may require all work registrants to participate in one or more components of their program, or limit participation (with the Agriculture Department's approval) by *further exempting* additional categories and individuals for whom participation is judged "impracticable" or not "cost-effective." But they must allow otherwise exempt recipients to participate as volunteers and may set up special programs for them.

Once the "pool" of work registrants who will be required to participate in an employment or training program is identified, welfare agencies must place at least half of them in one or more program components. Program components can include any or all of the following activities, at the welfare agency's option: supervised job search or training for job search, workfare, work experience or training programs, education programs to improve basic skills, or any other employment or training activity approved by the Agriculture Department.

Recipients who take part in an employment or training activity beyond work registration cannot be required to *work* more than the minimum wage equivalent of their household's benefit, and *total hours of participation* (including both work and any other required activity) cannot exceed 120 hours a month. Welfare agencies also must provide participants support for costs directly related to participation (e.g., transportation and child care). Agencies may limit this support to $25 per participant per month for all support costs other than dependent care, and to $160 per dependent per month for necessary dependent care.

Under current rules, State employment and training program performance is judged by the percentage of non-exempt work registrants placed in a program component.[13] However, recent amendments require the development of new standards whereby State performance will be measured against employment-related "outcomes" such as job placement and retention rates, reduced need for food stamp benefits, and improvement in educational levels. These standards are expected to be in place by early 1991.

Categorical eligibility rules and other limitations

A few food stamp rules deny food stamp eligibility for reasons other than financial need (limited income or liquid assets) or compliance with work registration or employment and training program requirements: (1) Where the head of household has voluntarily quit a job without good cause, the household's eligibility is barred for 90 days; (2) Households containing members on strike are ineligible, unless eligible prior to the strike; (3) Postsecondary students (in school half-time or more) who are physically and mentally fit for work and between ages 18 and 50 are ineligible unless they are assigned to school by a JTPA or other employment and training program, are employed at least 20 hours a week or participating in a federally financed work-study program, are a parent with responsibility for the care of a dependent child under age 6 or an AFDC recipient responsible for a child between 6 and 12 and do not have access to child care adequate to allow both work and school, or are a single parent responsible for a child under age 12; (4) Eligibility is barred to illegal or temporarily resident aliens; [14] (5) Eligibility is denied persons living in institutional settings, except for those in special SSI-approved small group homes for the disabled, persons living in drug addiction or alcoholic treatment programs, and persons in shelters for battered women and children or shelters for the homeless; (6) Boarders are ineligible unless they apply together with the household they are boarding with; (7) Eligibility is denied those who transfer assets for the purpose of qualifying for food stamps; (8) Those who intentionally violate food stamp rules are disqualified for specific time periods ranging from 6 months (on first violation) to permanently (on a third violation); (9) Those failing to provide social security numbers, or to cooperate in providing information needed to verify eligibility or benefit determinations, are ineligible.

---

[13] They must meet a minimum percentage requirement (50 percent); those sanctioned for noncompliance and volunteers are included as "placements" in this count.

BENEFITS

Food stamp benefits are a function of a household's size, its *counted (net)* monthly income, and maximum monthly benefit levels (in some cases, adjusted for geographic location). An eligible household's counted income is determined (as for eligibility), its maximum benefit level is established (depending on its size and location), and a benefit is calculated by subtracting its expected contribution (30 percent of its counted income) from its maximum allotment; maximum allotments are available only to those with no counted monthly income. In fiscal year 1990, monthly benefits averaged $59 a person and about $150 a household; in fiscal year 1991, average benefits are expected to be higher, $64 a person.

Maximum monthly allotments

Maximum monthly food stamp allotments are tied to the cost of purchasing a nutritionally adequate low-cost diet, as measured by the Agriculture Department's Thrifty Food Plan (TFP).[15] Maximum allotments are set at: the monthly cost of the TFP for a 4-person family consisting of a couple between ages 20 and 50 and 2 school-age children, adjusted for family size (using a formula reflecting economies of scale developed by the HNIS), increased by 3 percent, and rounded down to the nearest whole dollar. They are adjusted for food price inflation annually, each October, to reflect the cost of the TFP in the immediately previous June. Thus, maximum allotments for fiscal year 1991 represent the cost of the TFP in June 1990, adjusted for household size, increased by 3 percent, and rounded down.

---

[14] In addition, a legal alien's sponsor's income and assets may deny the alien eligibility.

[15] The TFP is the cheapest of four food plans designed by the Agriculture Department's Human Nutrition Information Service and is priced monthly (using data from price surveys done for the CPI-U).

Maximum allotments are standard in the 48 contiguous States and the District of Columbia; they are higher, reflecting substantially diferent food costs, in Alaska, Hawaii, Guam, and the Virgin Islands.

TABLE 6.—MAXIMUM MONTHLY FOOD STAMP ALLOTMENTS

[Effective October 1990 through September 1991]

Household size	48 States and D.C.	Alaska [1]	Hawaii	Guam	Virgin Islands
1 person	$105	$137	$172	$155	$135
2 persons	193	252	316	285	249
3 persons	277	361	452	409	356
4 persons	352	459	574	519	453
5 persons	418	545	682	616	538
6 persons	502	655	819	740	645
7 persons	555	723	905	818	713
8 persons	634	827	1,034	935	815
Each additional person	+79	+103	+129	+117	+102

[1] Maximum monthly allotments for designated urban areas of Alaska. Two separate higher allotment levels are applied in remote rural areas of Alaska. They are 29 and 56 percent higher than the urban allotments shown here.

Minimum and prorated benefits

Eligible one- and two-person households are guaranteed a minimum monthly food stamp allotment of $10. Minimum monthly benefits for other household sizes vary from year to year, depending on the relationship between changes in the income eligibility limits and the adjustments to the cost of the TFP, and in a few cases, benefits can be reduced to zero before income eligibility limits are exceeded (making some households eligible for no benefit). At present, minimum monthly allotments for households of three or more persons range from $13 to slightly over $100.

In addition, a household's calculated monthly allotment can be prorated (reduced) for one month. On application, a household's first month's benefit is reduced to reflect the date of application. If a previously participating household does not meet eligibility recertification requirements in a timely fashion, but does become certified for eligibility subsequently, benefits for the first month of its new certification period normally are prorated to reflect the date when recertification requirements were met.

Application processing and issuing food stamps

Food stamp benefits are normally issued monthly. The local welfare agency must either deny eligibility or make food stamps available within 30 days of initial application and must provide food stamps without interruption if an eligible household reapplies and fulfills recertification requirements in a timely manner. Households in immediate need because of little or no income and very limited cash assets, as well as the homeless and those with extraordinarily high shelter expenses, must be given expedited service (provision of benefits within 5 days of initial application).

Food stamp issuance is a welfare agency responsibility and issuance practices differ among welfare agencies. Most food stamp coupons are issued by: (1) providing (usually mailing) recipients an authorization-to-participate (ATP) card that is then turned in at a local issuance point (e.g., a bank or post office) when picking up their monthly allotment, or (2) mailing food stamp coupon allotments directly to recipients. However, several pilot projects issue cash benefits, and in a small but growing number of areas, electronic benefit transfer (EBT) systems are used. EBT systems replace coupons with an ATM-like card used to make food purchases at the point of sale by deducting the purchase amount from the recipient's food stamp benefit account.

Using food stamps

Food stamp benefits are issued in the form of booklets of coupons. The smallest coupon denomination is $1; if change of less than $1 is due on a food stamp purchase, it is returned in cash. Typically, participating households use their food stamps in approved grocery stores to buy food items for home preparation and consumption. However, the actual list of approved uses for food stamps is more extensive, and includes: (1) food for home preparation and consumption, not including alcohol, tobacco, or hot foods intended for immediate consumption; (2) seeds and plants for use in gardens to produce food for personal consumption; (3) in the case of the elderly and SSI recipients (and their spouses), meals prepared and served through approved communal dining programs for the elderly and disabled; (4) in the case of the elderly and those who are disabled to an extent that they cannot prepare all of their meals, home-delivered meals provided by programs for the homebound; (5) meals prepared and served to residents of drug addiction and alcoholic treatment programs, small group homes for the disabled, shelters for battered women and children, and shelters or other establishments serving the homeless; and (6) where the household lives in certain remote areas of Alaska, equipment for procuring food by hunting and fishing (e.g., nets, hooks, fishing rods, and knives). As noted earlier, sales taxes may not be charged on food stamp purchases.

INTERACTION WITH CASH ASSISTANCE PROGRAMS

The Food Stamp program is intertwined with cash assistance in two ways: it is administratively linked to cash welfare aid at the State and local levels, and its recipient population is made up largely of recipients of other government benefits.

At the State and local levels, the Food Stamp program is administered by the same welfare offices and personnel that administer cash assistance such as AFDC and general assistance. And joint food stamp/cash welfare application and interview procedures are the general rule. This coadministration does not apply for most elderly or disabled persons, whose SSI cash assistance is typically administered through Social Security Administration offices, although these offices do provide limited intake services for the Food Stamp program.

For most persons participating in the Food Stamp program, food stamp aid represents a second or third form of government payment. Fewer than 20 percent of food stamp households rely solely on nongovernmental sources for their cash income, although over 25 percent have some income from these sources (e.g., earnings, private retirement income). According to quality control data, the AFDC program contributes to the income of about 40 percent of food stamp households, and for almost all of them AFDC is their only cash income. SSI benefits go to some 20 percent of food stamp households, and almost one-third have no other income. About 20 percent of food stamp households receive social security or railroad retirement benefits. And nearly 15 percent are paid general assistance, unemployment insurance, or workers' compensation benefits.

TABLE 7.—CHARACTERISTICS OF FOOD STAMP HOUSEHOLDS: 1976–88

[In percent]

Food stamp recipient households	Year and month survey was conducted											
	1976 (Sept.)	1978 (Feb.)	1979 (Nov.)	1980 (Aug.)	1981 (Aug.)	1982 (Aug.)	1983 (Feb.)	1984 (Aug.)	1985 (Summer)	1986 (Summer)	1987 (Summer)	1988 (Summer)
With gross monthly income:												
Below the Federal poverty levels	82	87	82	87	90	95	93	93	94	93	94	92
Between the poverty levels and 125/130 percent of the poverty levels [1]	11	8	14	10	9	5	7	6	6	6	6	8
Above 125 percent/130 percent of the poverty levels [1]	7	5	4	2	1	*	*	1	*	*	*	*
With earnings	21	19	20	19	20	18	20	19	20	21	21	20
With public assistance income [2]	70	73	57	65	69	69	75	71	68	69	74	72
With AFDC income	43	43	34	NA	40	42	50	42	39	38	41	42
With SSI income	20	22	20	18	19	18	18	18	19	18	21	20
With children	57	NA	55	60	56	58	68	61	59	61	61	61
And nonelderly female heads of household	44	NA	40	NA	43	45	52	47	46	48	50	50
With elderly members [3]	17	17	24	23	21	20	18	22	21	20	21	19
With elderly female heads of household [3]	10	10	15	NA	14	14	12	16	16	15	15	14
Average household size	3.0	3.0	2.7	2.8	2.7	2.8	2.9	2.8	2.7	2.7	2.7	2.6

---

[1] For 1976 and 1978, percentages shown indicate the proportions of households with incomes between the poverty levels and 125 percent of the poverty levels, and the proportions of households with incomes above 125 percent of the poverty levels. For later years, percentages shown indicate the proportions of households with incomes between the poverty levels and 130 percent of the poverty levels, and the proportions of households with incomes above 130 percent of the poverty levels.

[2] Public assistance income includes AFDC, SSI, and general assistance.

[3] For 1976 and 1978, elderly members and heads of household include those age 65 or older. For later years, elderly members and heads of household include those age 60 or older.

* Less than 0.5 percent.

Source: U.S. Department of Agriculture (Food and Nutrition Service) surveys of the characteristics of food stamp households.

Compiled by the Congressional Research Service.

FOOD STAMP PARTICIPATION RATES

Table 8 shows gross food stamp participation rates using three different measures for the United States from 1975 to 1990. The actual number of food stamp participants has fluctuated widely over the last 15 years, reaching its highest level of 21.6 million (not including Puerto Rico) in 1983 and decreasing significantly to 18.7 million in 1988. As a percentage of the total U.S. resident population, food stamp participation rose significantly from a rate of 6.5 participants per 100 persons in 1978 to 9.3 percent in 1983, and has declined to 7.6 percent in 1989. In 1990, it had risen to 8.0 percent. In the poor and pretransfer poor populations, the food stamp participation rates in 1989 were 59.6 and 55.6 respectively, near the lowest levels shown in the table.

Two recent studies for August 1984 provide a more refined analysis of food stamp participation rates and the extent to which the food stamp program is serving its target population. A USDA study entitled "Food Stamp Program Participation Rates" estimates that 66 percent of individuals eligible for food stamps participated, and 60 percent of households eligible for food stamps participated. Those households participating received 80 percent of the benefits payable if all eligible households had participated.

A CBO study entitled "The Food Stamp Program: Eligibility and Participation" reported similar findings. The study estimates that between one-half and two-thirds of the approximately 30.4 million people who were eligible for food stamps in August 1984 participated in the program. In addition, particular subgroups of the eligible population participated at different rates. Among groups defined by monthly income levels, participation rates were highest for those with the lowest levels of income—between 60 percent and 85 percent for people with household income under $400 in August—and they declined as income levels rose.

Similarly, eligible people in households with no assets had relatively high participation rates—between 64 percent and 86 percent—while those with higher assets ($1,000 or more) had very low rates of participation—between 13 percent and 22 percent.

Certain demographic groups were more likely than others to participate. Eligible households with children had higher-than-average participation rates (between 59 percent and 81 percent), which reflects the fact that many poor children are participating in Aid to Families with Dependent Children (AFDC), and most AFDC families also receive food stamps. In contrast, participation rates for households with elderly members were lower, at 34 to 44 percent. Households without children or elderly members had still lower participation rates. These households include nonelderly single individuals and childless couples. Participation rates for this group ranged from 24 to 39 percent.

TABLE 8.—FOOD STAMP PARTICIPATION RATES IN THE UNITED STATES, 1975–90

Year	Number of food stamp participants (in millions)	Food stamp participation rates as percent of—		
		Total population[1]	Poor population[2]	Pre-transfer poor population[3]
1975	16.3	7.6	63.0	NA
1976	17.0	7.9	68.1	NA
1977	15.6	7.2	63.1	NA
1978	14.4	6.5	58.8	NA
1979	15.9	7.1	61.0	57.1
1980	19.2	8.4	65.6	60.7
1981	20.6	9.0	64.7	60.8
1982	20.4	8.8	59.3	56.3
1983	21.6	9.2	61.2	58.5
1984	20.9	8.8	62.0	58.5
1985	19.9	8.3	60.2	56.6
1986	19.4	8.0	59.9	56.2
1987	19.1	7.8	59.1	55.6
1988	18.7	7.6	58.9	55.2
1989	18.8	7.6	59.6	55.6
1990	20.0	8.0	NA	NA

[1] Data on total U.S. resident population can be found in appendix M, table 5.
[2] Data on the U.S. poor population can be found in appendix I, table 2.
[3] Data on the U.S. pre-transfer poor population can be found in appendix I, table 17.
NA—not available.

LEGISLATION

In the early 1980s, Congress enacted major revisions to the food stamp program to hold down costs and tighten administrative rules. The Omnibus Budget Reconciliation Act of 1981, the Agriculture and Food Act of 1981, and the Omnibus Budget Reconciliation Act of 1982 all contained amendments that the Congressional Budget Office has estimated held food stamp spending for fiscal years 1982 through 1985 nearly $7 billion (13 percent) below what would have been spent under pre-1981 law. These laws delayed various inflation indexing adjustments, reduced the maximum benefit guarantee by 1 percent (restored in 1984), established income eligibility ceilings at 130 percent of the Federal poverty levels, initiated prorating of first-month benefits, replaced the food stamp program in Puerto Rico with a nutrition assistance block grant, reduced benefits for those with earnings and high shelter expenses, ended eligibility for most postsecondary students and strikers, and raised fiscal penalties for States with high rates of erroneous benefit and eligibility determinations.

In 1985, the Food Security Act (P.L. 99-198) reauthorized food stamp appropriations through fiscal year 1990 and reversed the earlier trend, significantly liberalizing food stamp rules. Major new initiatives included: a requirement for States to implement employment and training programs for food stamp recipients, automatic food stamp eligibility for AFDC and SSI recipients, and a prohibition on collection of sales taxes on food stamp purchases. Benefits were raised for some disabled and those with earnings, high shelter costs, and dependent care costs. Puerto Rico's nutrition assistance block grant was increased. Eligibility standards were liberalized, primarily by increasing and easing limits on assets. This was followed by several laws in 1986 and 1987 that opened up access to and increased benefits for the homeless, liberalized treatment of student aid, energy assistance, and income received from employment programs for the elderly and charitable organizations, further added to benefits for those with high shelter costs, and allowed Washington State to operate a special AFDC/food stamp demonstration project (followed by similar authorization for Minnesota in 1989).

Legislation expanding eligibility and benefits continued into 1988 and 1989. The Hunger Prevention Act of 1988 (P.L. 100-435) increased food stamp benefits across the board, liberalized several eligibility and benefit rules, eased program access and administrative rules, and restructured the employment and training program and quality control system. The across-the-board benefit increase in maximum benefits (above normal inflation adjustments) called for by the act was 0.65 percent in fiscal year 1989, 2.05 percent in fiscal year 1990, and 3 percent in later years. Eligibility and benefit liberalizations included higher benefits for those with dependent care expenses, extension of liberal treatment for disabled applicants and recipients to new categories of disability, addition of a new income disregard for earned income tax credits, and liberalized treatment for farm households. Major provisions pertaining to program access and administration authorized 50-percent Federal cost sharing for State-option outreach activities, required coordination with cash welfare program application procedures, loosened rules governing monthly reporting and retrospective budgeting, allowed training of community volunteers to help screen applicants, and required, in some instances, issuance of the first 2 months' worth of benefits in a single allotment. Employment and training rules were revised by allowing some expansion in the types of activities supported (e.g., basic skills education), requiring increased support for participants' dependent care expenses, and mandating new performance standards for States. Finally, the food stamp quality control system was completely revamped to substantially reduce fiscal sanctions on States for erroneous benefit determinations, retroactively to fiscal year 1986.

Most recently, the 1990 Food, Agriculture, Conservation, and Trade Act (P.L. 101-624) reauthorized food stamp appropriations through fiscal year 1995. Although early versions of this act would have significantly liberalized food stamp eligibility and benefit rules, budget constraints dictated minimal expansions: limited revisions for postsecondary students, forgiveness of most pre-1986 quality control fiscal sanctions on States, a few changes in administrative rules to open up program access and strengthen penalties for trafficking, and new pilot projects and study commissions for welfare program coordination. In addition, other laws eliminated a special requirement for single food stamp/SSI applications for those about to be discharged from institutions and barred the food stamp program from counting (as a liquid asset) lump-sum earned income tax credit payments.

TABLE 9.—HISTORICAL FOOD STAMP STATISTICS

Fiscal year	Total Federal spending (in millions) [1]		Average monthly participation (in millions of persons)	Average monthly benefits (per person)		4-person maximum monthly allotment [2]
	Current dollars	Constant (1990) dollars [3]		Current dollars	Constant (1990) dollars [3]	
1972 [4]	$1,871	$5,847	11.1	$13.50	$42.20	$108
1973	2,211	6,381	12.2	14.60	42.10	112
1974	2,843	6,910	12.9	17.60	42.50	116
1975 [5]	4,624	10,232	17.1	21.40	47.00	150
1976	5,692	11,876	18.5	23.90	49.50	162
Transition quarter [6]	1,367	2,842	17.3	24.40	50.40	166
1977	5,469	10,920	17.1	24.70	49.00	166
1978	5,573	10,200	16.0	26.80	48.60	170
1979 [7]	6,995	11,512	17.7	30.60	49.90	182
1980	9,188	13,968	21.1	34.40	52.10	204
1981	11,308	15,724	22.4	39.50	54.80	209
1982	[8] 11,117	[8] 14,871	[9] 22.0	[10] 39.20	[10] 52.40	233
1983	[8] 12,733	[8] 16,785	[9] 23.2	[10] 43.00	[10] 56.70	253
1984	[8] 12,470	[8] 15,937	[9] 22.4	[10] 42.70	[10] 54.70	253
1985	[8] 12,599	[8] 15,741	[9] 21.4	[10] 45.00	[10] 56.40	264
1986	[8] 12,528	[8] 15,334	[9] 20.9	[10] 45.50	[10] 55.90	268
1987	[8] 12,539	[8] 14,699	[9] 20.6	[10] 45.80	[10] 53.80	271
1988	[8] 13,289	[8] 15,039	[9] 20.1	[10] 49.80	[10] 56.50	290
1989	[8] 13,815	[8] 14,692	[9] 20.2	[10] 51.90	[10] 55.30	300
1990 (est.)	[8] 16,517	[8] 16,517	[9] 21.5	[10] 59.00	[10] 59.00	331

[1] Federal costs, obligations including spending for benefits and administration.

[2] For the 48 contiguous States and the District of Columbia; as in effect at the beginning of the fiscal year, in current dollars.

[3] Constant dollar adjustments made using the overall Consumer Price Index for All Urban Consumers (CPI–U) for administrative cost and the CPI–U "food at home" component for benefits.

[4] The first fiscal year in which benefit and eligibility rules were, by law, nationally uniform and indexed for inflation.

[5] The first fiscal year in which food stamps were available nationwide.

[6] July through September 1976.

[7] The fiscal year in which the food stamp purchase requirement as eliminated, promoting increased participation among eligible households.

[8] Includes funding for Puerto Rico's nutrition assistance block grant.

[9] Includes persons receiving aid under Puerto Rico's nutrition assistance program, averaging 1.4 to 1.5 million persons a month.

[10] Does not reflect slightly lower benefits in Puerto Rico.

Notes: Allotment levels were indexed for inflation annually through calendar 1973, and semi-annually from January 1974 through calendar 1980. Since 1980, allotment levels have been increased in January 1981, October 1982, October 1983, October 1984, November 1984, October 1985, October 1986, October 1987, October 1988, and October 1989 ($331).

Figures presented in this table have been revised from similar tables presented in earlier versions of this print to reflect more recent spending information and more precise inflation adjustments for constant dollar amounts.

Compiled by the Congressional Research Service.

MEDICAID [16]

Medicaid, authorized under title XIX of the Social Security Act, is a Federal-State matching entitlement program providing medical assistance for low-income persons who are aged, blind, disabled, members of families with dependent children and certain other pregnant women and children. Within Federal guidelines, each State designs and administers its own program. Thus there is substantial variation among the States in terms of persons covered, types and scope of benefits offered, and amounts of payments for services.

Medicaid eligibility is generally linked to eligibility under programs within the jurisdiction of the Committee on Ways and Means, namely AFDC and SSI. Further, some poor aged persons are covered under both the Medicare and Medicaid programs.

ELIGIBILITY

Eligibility for Medicaid has traditionally been linked to actual or potential receipt of cash assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs. Legislation in the last decade has gradually extended coverage to low-income pregnant women and children who have no ties to the welfare system, and has provided partial coverage for new groups of low-income Medicare beneficiaries.

Medicaid is available to two broad classes of eligible persons: the "categorically needy" and the "medically needy." The two terms once distinguished between welfare-related beneficiaries and those qualifying only under special Medicaid rules. However, nonwelfare groups have been added to the "categorically needy" list over the years. As a result, the terms are no longer especially helpful in sorting out the various populations for whom mandatory or optional Medicaid coverage has been made available, and some analysts believe they should be abandoned. However, the distinction between the categorically and medically needy is still an important one, because the scope of covered services that States must provide to the categorically needy is much broader than the minimum scope of services for the medically needy.

All States must cover certain mandatory groups of categorically needy individuals.[17] Coverage of additional categorically needy groups is optional, as is coverage of the medically needy. The following discussion describes the mandatory and optional categorically eligible groups within each of the two basic populations served by Medicaid: families with children and the aged, blind, and disabled. The medically needy are discussed separately at the end of this section.

---

[16] For further information on the Medicaid program see: U.S. Congress, House Committee on Energy and Commerce, Medicaid Source Book: Background Data and Analysis, Energy and Commerce Committee Print 100–AA. U.S. Govt. Print. Off. November 1988.

[17] Arizona does not operate a traditional Medicaid program. Since 1982 it has operated a federally assisted medical assistance program for low-income persons under a demonstration waiver.

FAMILIES AND CHILDREN

AFDC-related groups

Mandatory.—States must provide Medicaid to all persons receiving cash assistance under AFDC, as well as to additional AFDC-related groups who are not actually receiving cash payments. These groups include: persons who do not receive a payment because the amount would be less than $10; persons whose payments are reduced to zero because of recovery of previous overpayments; certain work supplementation participants; certain children for whom adoption assistance agreements are in effect or for whom foster care payments are being made under title IV–E of the Social Security Act; persons ineligible for AFDC because of a requirement that may not be imposed under Medicaid; and persons who would be eligible for Medicaid except for the 20 percent 1972 Social Security increase.

States must also cover children under age 7 who meet the income and resources requirements for AFDC, but who do not meet the AFDC definition of a "dependent child." For example, the child may be in a two-parent family where the principal breadwinner is not unemployed. (This coverage class will become obsolete on July 1, 1991, when these children will be subsumed in a larger mandatory coverage group of poor children, to be discussed below.)

States are required to continue Medicaid for specified periods for certain families losing AFDC benefits after receiving them in at least 3 of the preceding 6 months. If the family loses AFDC benefits because of increased income from earnings or hours of employment, Medicaid coverage must be extended for 12 months. (During the second 6 months a premium may be imposed, the scope of benefits may be limited, or alternate delivery systems may be used.) If the family loses AFDC because of increased child or spousal support, coverage must be extended for 4 months. States are also required to furnish Medicaid to certain two-parent families whose principal earner is unemployed and who are not receiving cash assistance because the State is one of those permitted (under the Family Support Act of 1988) to set a time limit on AFDC coverage for such families.

Optional.—States are permitted, but not required, to provide coverage to additional AFDC-related groups. The most important of these are the "Ribicoff children," whose income and resources are within AFDC standards but who (like the mandatory under-age 7 group described earlier) do not meet the definition of "dependent child." States may cover these children up to a maximum age of 18, 19, 20, or 21, at the State's option, and may limit coverage to reasonable subgroups, such as children in two-parent families, those in privately subsidized foster care, or those who live in certain institutional settings. States may also furnish Medicaid to persons who would receive AFDC if the State's AFDC program were as broad as permitted under Federal law.

Non-AFDC pregnant women and children

Beginning in 1986, Congress has extended Medicaid to groups of pregnant women and children who are defined in terms of family income and resources, rather than in terms of their ties to the AFDC program.

Mandatory.—States are required to cover pregnant women and children under age 6 with family incomes below 133 percent of the Federal poverty income guidelines. (The State may impose a resource standard that is no more restrictive than that for SSI, in the case of pregnant women, or AFDC, in the case of children.) Coverage for pregnant women is limited to services related to the pregnancy or complications of the pregnancy; children receive full Medicaid coverage.

Effective July 1, 1991, States are also required to cover all children who are under age 19, who were born after September 30, 1983, and whose family income is below 100 percent of the Federal poverty level. (Coverage of such children through age 7 has been optional since OBRA 1987.) The 1983 start date means that coverage of 18-year-olds will take effect during fiscal year 2002.

Optional.—States are permitted, but not required, to cover pregnant women and infants under one year old with incomes below a State-established maximum that is above 133 percent of the poverty level but no more than 185 percent. As of July 1990, 24 States had made use of this option; 19 had set their income limits at the maximum of 185 percent.

AGED AND DISABLED PERSONS

SSI-related groups

Mandatory.—States are generally required to cover recipients of SSI. However, States may use more restrictive eligibility standards for Medicaid than those for SSI if they were using those standards on January 1, 1972 (before the implementation of SSI). States that have chosen to apply more restrictive standards are known as "section 209(b)" States, after the section of the Social Security Amendments of 1972 (Public Law 92-603) that established the option. There are 13 section 209(b) States:

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
Nebraska
New Hampshire
North Carolina
North Dakota
Ohio
Oklahoma
Virginia

Three of these States used different definitions of disability (of these, two excluded children under 18), ten used more restrictive standards related to income or income determination, and all but two used some more restrictive standards related to allowable resources or resource determination. States using more restrictive income standards must allow applicants to deduct medical expenses from income (not including SSI or State supplemental payments, SSP) in determining eligibility. This process is known as "spenddown." For example, if an applicant has a monthly income of $400 (not including any SSI or SSP) and the State's maximum allowable income is $350, the applicant would be required to incur $50 in medical expenses before qualifying for Medicaid. As will be discussed below, the spenddown process is also used in establishing medically needy eligibility.

States must continue Medicaid coverage for several defined groups of individuals who have lost SSI or SSP eligibility. The "qualified severely impaired" are disabled persons who have returned to work and have lost eligibility as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all non-disability criteria for SSI except income. Medicaid must be continued if such an individual needs continued medical assistance to continue employment and the individual's earnings are insufficient to provide the equivalent of SSI, Medicaid, and attendant care benefits the individual would qualify for in the absence of earnings. States must also continue Medicaid coverage for persons who were once eligible for both SSI and Social Security payments and who lose SSI because of a cost of living adjustment (COLA) in their Social Security benefits. Similar Medicaid continuations have been provided for certain other persons who lose SSI as a result of eligibility for or increases in Social Security or veterans' benefits. Finally, States must continue Medicaid for certain SSI-related groups who received benefits in 1973, including "essential persons" (persons who care for a disabled individual).

Optional.—States are permitted to provide Medicaid to individuals who are not receiving SSI but are receiving State-only supplementary cash payments.

Qualified Medicare beneficiaries and related groups

Mandatory.—Effective January 1, 1991, States must provide limited Medicaid coverage for "qualified Medicare beneficiaries" (QMBs). These are aged and disabled persons who are receiving Medicare, whose income is below 100 percent of the Federal poverty level, and whose resources do not exceed twice the allowable amount under SSI. Five section 209(b) States that use more restrictive maximum income standards for Medicaid than for SSI (Hawaii, Illinois, North Carolina, Ohio, Utah) may use an income limit of 95 percent of poverty until January 1, 1992. States must pay Medicare part B premiums (and, if applicable, part A premiums) for QMBs, along with required Medicare coinsurance and deductible amounts.

Effective January 1, 1993, all States must pay part B premiums (but not part A premiums or part A or B coinsurance and deductibles) for beneficiaries who would be QMBs except that their incomes are between 100 percent and 110 percent of the poverty level; the upper limit rises to 120 percent on January 1, 1995.

States are also required to pay part A premiums, but no other expenses, for "qualified disabled and working individuals." These are persons who formerly received Social Security disability benefits and hence Medicare, have lost eligibility for both programs, but are permitted under Medicare law to continue to receive Medicare in return for payment of the part A premium. Medicaid must pay this premium on behalf of such individuals who have incomes below 200 percent of poverty and resources no greater than twice the SSI standard.

Optional.—States are permitted to provide full Medicaid benefits, rather than just Medicare premiums and cost-sharing, to QMBs who meet a State-established income standard that is no higher than 100 percent of the Federal poverty level.

Institutionalized persons and related groups (all optional)

States may provide Medicaid to certain otherwise ineligible groups of persons who are in nursing facilities or other institutions, or who would require institutional care if they were not receiving alternative services at home or in the community.

States may establish a special income standard for institutionalized persons, not to exceed 300 percent of the maximum SSI benefits payable to a person who is living at home and has no other resources. States may also provide Medicaid to persons who would qualify for SSI but for the fact that they are in an institution.

A State may obtain a waiver under section 2176 of OBRA 1981 to provide home and community-based services to a defined group of individuals who would otherwise require institutional care. Persons served under such a waiver may receive Medicaid coverage if they would be eligible if in an institution. Such individuals may also be covered in a State that terminates its waiver program in order to take advantage of a new, no-waiver home and community-based services option created by OBRA 1990.

A State may also provide Medicaid to several other classes of persons who need the level of care provided by an institution and would be eligible if they were in an institution. These include children who are being cared for at home, persons of any age who are ventilator-dependent, and persons receiving hospice benefits in lieu of institutional services.

THE MEDICALLY NEEDY (ALL OPTIONAL)

Forty States and other jurisdictions provide Medicaid to at least some groups of "medically needy" persons. These are persons who meet the nonfinancial standards for inclusion in one of the groups covered under Medicaid, but who do not meet the applicable income or resource requirements for categorically needy eligibility. The State may establish higher income or resource standards for the medically needy. In addition, individuals may spend down to the medically needy standard by incurring medical expenses, in the same way that SSI recipients in section 209(b) States may spend down to Medicaid eligibility. For the medically needy, spenddown may involve the reduction of assets, as well as of income.

The State may set its separate medically needy income standard for a family of a given size at any level up to 133⅓ percent of the maximum payment for a similar family under the State's AFDC program. States may limit the groups of individuals who may receive medically needy coverage. If the State provides any medically needy program, however, if must include all children under 18 who would qualify under one of the mandatory categorically needy groups, and all pregnant women who would qualify under either a mandatory or optional group, if their income or resources were lower.

As of October 1, 1990, the following States covered some groups of the medically needy:

American Samoa
Arkansas
California
Connecticut
District of Columbia
Florida
Georgia
Hawaii
Illinois
Iowa
Kansas
Kentucky

Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Montana
Nebraska
New Hampshire
New Jersey
New York
North Carolina
North Dakota
Northern Mariana Islands
Oklahoma
Oregon
Pennsylvania
Puerto Rico
Rhode Island
Tennessee
Texas
Utah
Vermont
Virgin Islands
Virginia
Washington
West Virginia
Wisconsin

MEDICAID AND THE POOR

In 1989, Medicaid covered 8.6 percent of the total U.S. population (excluding institutionalized persons) and 42.3 percent of those with incomes below the Federal poverty level. Because categorical eligibility requirements for children are less restrictive than those for adults, poor children are much more likely to receive coverage. Table 10 shows Medicaid eligibility by age and income status in 1989, as reported in the March 1990 Current Population Survey (CPS) conducted by the Census Bureau. Note that persons shown as receiving Medicaid may have had other health coverage as well. Nearly all the elderly, for example, have Medicare and/or private coverage.

Children under age 6 with family incomes below poverty are most likely to be covered. Coverage rates drop steadily with age and income until age 65. The 1989 data do not reflect the full impact of recent eligibility expansions, such as mandatory coverage of low-income children. Over time, it is expected that more children and senior citizens will be covered, while coverage rates for younger adults may remain constant.

TABLE 10.—MEDICAID COVERAGE BY AGE AND INCOME STATUS, 1989

[All numbers are in thousands]

Age	Medicaid	Total	Percent with Medicaid
Poor:			
0 to 5	3,201	5,072	63.1
6 to 18	4,145	8,173	50.7
19 to 44	3,735	10,993	34.0
45 to 64	1,184	3,927	30.2
65 and over	1,060	3,369	31.5
Total	13,325	31,534	42.3
Family income between 100 and 133 percent of poverty:			
0 to 5	477	1,764	27.0
6 to 18	528	2,962	17.8
19 to 44	699	5,169	13.5
45 to 64	279	1,845	15.1
65 and over	485	3,069	15.8
Total	2,468	14,809	16.7

TABLE 10.—MEDICAID COVERAGE BY AGE AND INCOME STATUS, 1989—Continued

[All numbers are in thousands]

Age	Medicaid	Total	Percent with Medicaid
Family income between 133 percent and 185 percent of poverty:			
0 to 5	335	2,412	13.9
6 to 18	477	4,821	9.9
19 to 44	603	8,580	7.0
45 to 64	243	3,196	7.6
65 and over	378	4,454	8.5
Total	2,036	23,463	8.7
Family income greater than 185 percent of poverty:			
0 to 5	523	13,258	3.9
6 to 18	670	29,240	2.3
19 to 44	944	77,447	1.2
45 to 64	455	37,568	1.2
65 and over	653	18,674	3.5
Total	3,245	176,187	1.8
All individuals:			
0 to 5	4,536	22,506	20.2
6 to 18	5,820	45,196	12.9
19 to 44	5,981	102,190	5.9
45 to 64	2,161	46,535	4.6
65 and over	2,576	29,565	8.7
Total	21,074	245,992	8.6

Source: Current Population Survey (CPS), Annual March Income Supplement. Table prepared by CRS. The table excludes persons in institutions and approximately 300,000 children under age 15 whose income was not reported. The Medicaid counts are lower than those reported by HCFA, because some beneficaries fail to report their coverage on the CPS. Some may also underreport their income. In addition, the income used to determine poverty status in this table includes cash welfare, while Medicaid eligibility is based on income prior to the receipt of welfare benefits.

SERVICES

States are required to offer the following services to categorically needy recipients under their Medicaid programs: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing facility (SNF) services for those over age 21; home health services for those entitled to SNF care; early and periodic screening, diagnosis, and treatment (EPSDT) for those under age 21; family planning services and supplies; physicians' services, and nurse-midwife services. OBRA 1989 requires States to provide ambulatory services offered by federally qualified health centers, effective April 1, 1990, and services furnished by certified family or pediatric nurse practitioners, effective July 1, 1990. States may also provide additional medical services such as drugs, intermediate care facility (ICF) services, eyeglasses, inpatient psychiatric care for individuals under age 21 or over 65 (see table 22). OBRA 1990 adds two new optional services: home and community-based services for the functionally disabled elderly and community supported living arrangement services for the developmentally disabled. Total expenditures under these services are capped. States are permitted to establish limitations on the amount of care provided under a service category (such as limiting the number of days of covered hospital care or number of physicians' visits). Certain services to children may not be limited.

Federal law establishes the following requirements for coverage of the medically needy: (1) if a State provides medically needy coverage to any group it must provide ambulatory services to children and prenatal and delivery services for pregnant women; (2) if a State provides institutional services for any medically needy group it must also provide ambulatory services for this population group; and (3) if the State provides medically needy coverage for persons in intermediate care facilities for the mentally retarded (ICF/MRs) or institutions for mental diseases, it must offer to all groups covered in its medically needy program the same mix of institutional and noninstitutional services as required under prior law (that is, either all of the mandatory services or alternatively the care and services listed in 7 of the 25 paragraphs in the law defining covered services).

FINANCING

The Federal Government helps States share in the cost of Medicaid services by means of a variable matching formula which is adjusted annually. The matching rate, which is inversely related to a State's per capita income, can range from 50 percent to 83 percent though currently the highest rate is 79.93 percent. Federal matching for the territories is set at 50 percent with a maximum dollar limit placed on the amount each territory can receive. The Federal share of administrative costs is 50 percent for all States except for certain items where the authorized rate is higher.

REIMBURSEMENT POLICY

States establish their own service reimbursement policies within general Federal guidelines. OBRA89 codified the regulatory requirement that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. Beginning April 1, 1990, States are required to submit to the Secretary their payment rates for pediatric and obstetrical services along with additional data that will assist the Secretary in evaluating the State's compliance with this requirement.

Until 1980, States were required to follow Medicare rules in paying for institutional services. The Boren amendment, enacted with respect to nursing homes in 1980 and extended to hospitals in 1981, authorized States to establish their own payment systems, as long as rates were reasonable and adequate to meet the costs of efficiently and economically operated facilities. Rates for hospitals must also be sufficient to assure reasonable access to inpatient services of adequate quality. A Supreme Court ruling in 1990, *Wilder* v. *Virginia Hospital Association,* affirmed that hospitals have the right under this rule to seek Federal court review of State reimbursement levels. Suits alleging inadequate hospital payment are now pending in a number of States.

In addition to meeting general adequacy tests, State hospital reimbursement systems must provide for additional payments to facilities serving a disproportionate share of low-income patients. Unlike the comparable Medicare payments, Medicaid payments must follow a formula that considers a hospital's charity patients as well as its Medicaid caseload.

OBRA 1990 establishes new rules for Medicaid reimbursement of prescription drugs. The law requires manufacturers of prescription drugs to provide rebates to State Medicaid programs. States will be required to cover all the drugs manufactured by a firm entering into a rebate agreement. For calendar year 1991, required rebates range from 10 to 25 percent, depending on the nature of the drug and the discounts offered to other purchasers. The law establishes a 4-year moratorium on reductions in most payment rates for pharmacists.

Practitioners and providers are required to accept payments under the program as payment in full for covered services except where nominal cost-sharing charges may be required. States may generally impose such charges with certain exceptions. They are precluded from imposing such charges on services for children under 18, services related to pregnancy, family planning or emergency services, HMO services for the categorically needy, and services provided to SNF or ICF inpatients who are required to spend all of their income for medical care except for a personal needs allowance.

ADMINISTRATION

Medicaid is a State-administered program. At the Federal level, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services is responsible for overseeing State operations.

Federal law requires that a single State agency be charged with administration of the Medicaid program. Generally, that agency is either the State welfare agency, the State health agency, or the umbrella human resources agency. The single State agency may contract with other State entities to conduct some program functions. Further, States may process claims for reimbursement themselves or contract with fiscal agents or health insuring agencies to process these claims.

RECENT LEGISLATIVE CHANGES

The following is a summary of the major Medicaid changes enacted as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Public Law 101-508:

1. *Reimbursement for prescribed drugs.*—The law requires manufacturers of prescription drugs to provide rebates to State Medicaid programs. States will be required to cover all the drugs manufac-

tured by a firm entering into a rebate agreement. For calendar year 1991, required rebates range from 10 to 25 percent. Beginning in 1993, States are required to have prospective (i.e., point-of-sale) and retrospective drug utilization review (DUR) programs, to assure that prescriptions are appropriate and medically necessary. Enhanced Federal matching payments are provided for State administrative costs related to the rebate and DUR programs. The law establishes a 4-year moratorium on reductions in most payment rates for pharmacists.

2. *Required payment of premiums and cost-sharing for enrollment under group health plans where cost-effective.*—Effective January 1, 1991, the law requires States to pay premiums for group health plans for which Medicaid beneficiaries are eligible, when it is cost-effective to do so. Guidelines for determining cost-effectiveness are to be issued by the Secretary. States will pay any cost-sharing required by a plan and continue to furnish any Medicaid benefits not covered under the plan. Providers under group health plans will be required to accept plan payment as payment in full for Medicaid enrollees.

3. *Protection of low-income Medicare beneficiaries.*—The law accelerates phase-in of the requirement that States pay Medicare premiums and cost-sharing for QMBs, Medicare beneficiaries with incomes below 100 percent of the Federal poverty level; for all but 5 States, the requirement is effective January 1, 1991. All States must pay part B premiums (but not part A premiums or cost-sharing) for beneficiaries with incomes below 110 percent of the poverty level in 1993 and below 120 percent in 1995.

4. *Child health provisions.*—Effective July 1, 1991, all States are required to cover children under age 19 who were born after September 30, 1983, and whose family income is below 100 percent of the Federal poverty level. States are required to accept Medicaid applications for mothers and children at locations other than welfare offices, and are required to continue benefits for pregnant women until 2 months after the end of the pregnancy, and for infants through the first year of life. States are required to make additional payments for outlier cases and are prohibited from imposing durational limits on coverage for patients who are under age 1 in any hospital or under age 6 in a disproportionate share hospital.

5. *Home and community-based care as optional service.*—The law permits States to provide home and community-based services to functionally disabled Medicaid beneficiaries aged 65 or over, effective the later of July 1, 1991, or 30 days after the publication of interim rules. States will be permitted to limit eligibility for the services without waivers and thus to provide the services without meeting cost-effectiveness tests. Federal matching payments cannot exceed 50 percent of what it would have cost to provide Medicare nursing facility care to the same group of beneficiaries. Total Federal expenditures will be limited to $580 million over the period fiscal years 1991 to 1995.

6. *Community supported living arrangements.*—The law permits between two and eight States to provide community supported living arrangement services to developmentally disabled individuals who live with their families or in small community residential settings, effective the later of July 1, 1991, or 30 days after the pub-

lication of interim rules. Services will include personal assistance, training and habilitation, and other services needed to help with activities of daily living. Total Federal expenditures will be limited to $100 million over the period fiscal years 1991 to 1995.

7. *Payments for COBRA continuation coverage.*—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272) provides that employees or dependents leaving an employee health insurance group in a firm with 20 or more employees must be offered an opportunity to continue buying insurance through the group for 18 to 36 months (depending on the reason for leaving the group). OBRA 1990 permits State Medicaid programs to pay for COBRA continuation coverage, when it is cost effective to do so, effective January 1, 1991. States may pay premiums for individuals with incomes below 100 percent of poverty and resources less than twice the SSI limit who are eligible for continuation coverage under a group health plan offered by an employer with 75 or more employees.

8. *Miscellaneous.*—The law establishes demonstration projects in three to four States to test the effect of providing Medicaid to families with incomes below 150 percent of the Federal poverty level that do not meet categorical eligibility requirements, and projects in two States to provide Medicaid coverage for early intervention services for HIV-infected individuals who do not meet disability criteria. States are permitted to use provider-specific taxes to finance the State share of Medicaid spending, and the moratorium on changes in rules on State use of voluntary provider contributions is extended through December 31, 1991. The law also includes new measures to ensure the quality of physician services under Medicaid, technical corrections in nursing home reform provisions, and numerous other technical and miscellaneous amendments.

PROGRAM DATA

Federal Medicaid outlays are estimated (in the absence of legislative changes) at $59.9 billion in fiscal year 1992, a 16.2 percent increase over the $51.6 billion estimated for fiscal year 1991.

Detailed information on State Medicaid programs is available in the House Energy and Commerce Committee Print 100-AA, Medicaid Source Book: Background Data and Analysis, November 1988.

TABLE 11.—HISTORY OF MEDICAID PROGRAM COSTS

Fiscal year	Total		Federal		State	
	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase
1966 [1]	$1,658	....	$789	....	$869	....
1967 [1]	2,368	42.8	1,209	53.2	1,159	33.4
1968 [1]	3,686	55.7	1,837	51.9	1,849	59.5
1969 [1]	4,166	13.0	2,276	23.9	1,890	2.2
1970 [1]	4,852	16.5	2,617	15.0	2,235	18.3
1971	6,176	27.3	3,374	28.9	2,802	25.4
1972 [2]	8,434	36.6	4,361	29.3	4,074	45.4
1973	9,111	8.0	4,998	14.6	4,113	1.0
1974	10,229	12.3	5,833	16.7	4,396	6.9
1975	12,637	23.5	7,060	21.0	5,578	26.9
1976	14,644	15.9	8,312	17.7	6,332	13.5
TQ [3]	4,106	NA	2,354	NA	1,752	NA
1977	17,103	[4] 16.8	9,713	[4] 16.9	7,389	[4] 16.7
1978	18,949	10.8	10,680	10.0	8,269	11.9
1979	21,755	14.8	12,267	14.9	9,489	14.8
1980	25,781	18.5	14,550	18.6	11,231	18.4
1981	30,377	17.8	17,074	17.3	13,303	18.4
1982	32,446	6.8	17,514	2.6	14,931	12.2
1983	34,956	7.7	18,985	8.4	15,971	7.0
1984	37,569	7.5	20,061	5.7	17,508	9.6
1985 [5]	40,917	8.9	[6] 22,655	12.9	[6] 18,262	4.3

TABLE 11.—HISTORY OF MEDICAID PROGRAM COSTS—Continued

Fiscal year	Total		Federal		State	
	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase
1986	44,851	9.6	24,995	10.3	19,856	8.7
1987	49,344	10.0	27,435	9.8	21,909	10.3
1988	54,116	9.7	30,462	11.0	23,654	8.0
1989	61,246	13.2	34,604	13.6	26,642	12.6
1990	72,492	18.4	41,103	18.8	31,389	17.8
1991 (current law estimate)	90,289	24.6	51,555	25.4	38,734	23.4
1992 (current law estimate)	104,354	15.6	59,899	16.2	44,455	14.8

---

[1] Includes related programs which are not separately identified though for each successive year a larger portion of the total represents Medicaid expenditures. As of Jan. 1, 1970, Federal matching was only available under Medicaid.

[2] Intermediate care facilities (ICFs) transferred from the cash assistance programs to Medicaid effective January 1, 1972; data for prior periods do not include these costs.

[3] Transitional quarter (beginning of Federal fiscal year moved from July 1 to Oct. 1).

[4] Represents increase over fiscal year 1976, i.e., five calendar quarters.

[5] Includes transfer of function of State fraud control units to Medicaid from Office of Inspector General.

[6] Temporary reductions in Federal payments authorized for fiscal years 1982–84 were discontinued in fiscal year 1985.

[7] Preliminary.

Note: Totals may not add due to rounding.

Source: "Budget of the U.S. Government" fiscal years 1969–92, and Health Care Financing Administration, Division of Budget.

TABLE 12.—UNDUPLICATED NUMBER OF MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972–89

[Number in thousands]

Fiscal year	Total	Aged 65 or over	Blindness	Permanent and total disability	Dependent children under age 21	Adults in families with dependent children	Other [1]
1972	17,606	3,318	108	1,625	7,841	3,137	1,576
1973	19,622	3,496	101	1,804	8,659	4,066	1,495
1974	21,462	3,732	135	2,222	9,478	4,392	1,502
1975	22,007	3,615	109	2,355	9,598	4,529	1,800
1976	22,815	3,612	97	2,572	9,924	4,774	1,836
1977 [2]	22,832	3,636	92	2,710	9,651	4,785	1,959
1978	21,965	3,376	82	2,636	9,376	4,643	1,852
1979	21,520	3,364	79	2,674	9,106	4,570	1,727
1980 [3]	21,605	3,440	92	2,819	9,333	4,877	1,499
1981 [3]	21,980	3,367	86	2,993	9,581	5,187	1,364
1982 [3]	21,603	3,240	84	2,806	9,563	5,356	1,434
1983 [3]	21,554	3,371	77	2,844	9,535	5,592	1,129
1984 [3]	21,607	3,238	79	2,834	9,684	5,600	1,187
1985 [3]	21,814	3,061	80	2,937	9,757	5,518	1,214
1986 [3]	22,515	3,140	82	3,100	10,029	5,647	1,362
1987 [3]	23,109	3,224	85	3,296	10,168	5,599	1,418
1988 [3]	22,907	3,159	86	3,401	10,037	5,503	1,343
1989 [3]	23,511	3,132	95	3,496	10,318	5,717	1,175

[1] This category is composed predominantly of children not meeting the definition of "dependent" children, e.g., "Ribicoff children."

[2] Fiscal year 1977 began in October 1976 and was the first year of the new Federal fiscal cycle. Before 1977, the fiscal year began in July.

[3] Beginning in fiscal year 1980, recipients' categories do not add to the unduplicated total due to the small number of recipients that are in more than one category during the year.

Source: HCFA, BDMS, OSDM, Division of Medicaid Statistics, Fiscal Years 1972–1988, Office of the Actuary, Fiscal year 1989.

TABLE 13.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1989

State	Total recipients [1]	Aged	Blind	Disabled	AFDC children	AFDC adults	Other title XIX [2]
Alabama	321,279	67,020	1,618	78,552	102,345	51,247	19,887
Alaska	36,288	2,857	65	3,422	20,998	8,946	0
Arkansas	241,677	45,263	1,251	47,929	73,571	38,819	34,844
California	3,325,968	418,253	23,726	503,189	1,377,603	905,843	33,979
Colorado	190,807	35,844	180	28,259	79,559	42,833	4,132
Connecticut	228,108	46,038	253	28,839	91,846	47,297	13,836
Delaware	38,335	4,865	95	6,054	19,171	10,097	1,017
District of Columbia	98,374	11,446	28	16,075	47,852	22,970	3
Florida	875,585	145,593	3,109	148,518	363,433	195,936	18,996
Georgia	581,543	97,072	16,918	113,865	228,693	116,020	8,975
Hawaii	93,250	19,464	155	15,700	46,367	26,984	0
Idaho	46,932	6,521	22	8,383	21,141	10,343	522
Illinois	1,043,044	85,329	1,268	162,182	525,739	249,464	19,062
Indiana	312,294	43,863	1,016	51,629	137,483	75,102	291
Iowa	224,721	33,251	656	30,483	87,967	56,122	15,521
Kansas	176,869	23,217	145	19,592	79,150	49,568	1,084
Kentucky	430,575	51,931	1,974	84,743	154,279	104,482	25,878
Louisiana	526,499	87,641	1,858	76,534	244,403	105,080	10,983
Maine	122,720	19,888	214	21,368	47,616	28,373	4,846
Maryland	321,218	42,926	354	47,953	152,420	71,266	6,299
Massachusetts	582,418	104,801	8,046	94,104	209,656	125,184	40,626
Michigan	1,117,196	96,917	2,548	169,313	622,771	341,293	72,768

Minnesota	322,594	46,295	536	28,322	114,540	106,909	25,992
Mississippi	405,987	57,536	1,692	70,722	150,677	76,552	48,808
Missouri	406,088	62,852	1,193	65,416	161,887	86,747	27,993
Montana	61,054	6,861	85	8,864	24,134	15,710	2,341
Nebraska	108,709	16,659	216	12,603	41,531	24,119	13,581
Nevada	41,290	6,760	427	6,592	18,082	9,995	2,040
New Hampshire	36,042	8,563	316	5,323	9,060	12,762	18
New Jersey	533,015	70,125	1,165	84,373	248,557	120,277	1,485
New Mexico	113,173	12,928	519	20,246	51,626	25,634	2,220
New York	2,253,385	337,899	3,960	341,755	982,328	457,399	130,044
North Carolina	487,189	91,416	1,272	65,430	204,618	121,572	2,881
North Dakota	46,515	9,136	37	5,783	16,596	10,130	4,485
Ohio	1,133,963	102,970	1,560	137,706	566,225	277,369	48,133
Oklahoma	253,103	51,339	583	32,777	109,729	44,244	14,431
Oregon	213,222	22,273	1,082	24,941	103,432	61,494	0
Pennsylvania	1,100,787	137,919	1,217	178,885	618,792	262,085	70,921
Rhode Island	103,036	19,052	299	20,740	40,846	21,899	783
South Carolina	277,048	45,574	1,804	63,540	110,721	55,405	4
South Dakota	44,523	8,280	135	7,508	18,836	9,713	0
Tennessee	542,595	78,761	2,498	110,082	239,031	104,572	7,651
Texas	1,184,889	216,748	4,738	137,559	551,262	272,157	2,425
Utah	94,284	7,358	88	9,685	39,680	29,594	5,929
Vermont	53,406	9,769	84	7,695	21,958	13,259	332
Virginia	345,367	62,814	1,163	56,282	146,603	78,505	0
Washington	427,199	49,659	394	61,360	231,239	135,825	8,767
West Virginia	240,025	25,014	273	35,643	101,182	76,126	1,787
Wisconsin	402,091	71,190	1,234	78,934	203,028	109,512	7,893

TABLE 13.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1989—Continued

State	Total recipients [1]	Aged	Blind	Disabled	AFDC children	AFDC adults	Other title XIX [2]
Wyoming	31,029	4,906	80	2,789	12,592	14,872	1,300
Puerto Rico	1,300,687	0	679	56,567	438,265	396,496	408,694
Virgin Islands	12,694	964	16	790	7,111	3,188	625
All jurisdictions	23,510,689	3,131,620	94,844	3,495,598	10,318,231	5,717,380	1,175,112
United States	22,197,308	3,130,656	94,149	3,438,241	9,872,855	5,317,696	765,793

---

[1] Total is unduplicated count of recipients. A small number of recipients are in more than one category during the year. Total recipients include unknowns which are not reflected in this table.

[2] This category is composed primarily of children not meeting the definition of dependent child, e.g., "Ribicoff Children".

Source: HCFA, BDMS, OSDM, Office of Statistics and Data Management, Division of Medicaid Statistics.

TABLE 14.—MEDICAID EXPENDITURES BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1989

[In millions]

State	Total expenditure	Aged	Blind	Disabled	AFDC children	AFDC adults	Other title XIX	Aged, blind and disabled as a percent of total exp.	AFDC children as a percent of total exp.
Alabama	509	181	3	207	39	54	25	76.8	7.7
Alaska	124	28	(1)	39	35	23	0	54.0	28.2
Arkansas	491	162	4	188	53	36	49	72.1	10.8
California	5,498	1,253	72	2,178	818	1,058	49	63.7	14.9
Colorado	452	158	3	190	48	40	14	77.7	10.6
Connecticut	1,027	514	2	338	65	65	43	83.2	6.3
Delaware	110	43	1	42	12	11	1	77.7	10.9
District of Columbia	244	112	(1)	95	21	17	(1)	84.8	8.6
Florida	1,912	786	8	627	234	231	25	74.3	12.2
Georgia	1,226	357	43	481	140	194	11	71.9	11.4
Hawaii	159	71	(1)	38	24	26	0	68.6	15.1
Idaho	134	43	(1)	64	15	12	1	79.9	11.2
Illinois	2,103	431	7	1,082	310	240	34	72.3	14.7
Indiana	1,157	369	6	502	132	140	(1)	75.8	11.4
Iowa	522	148	2	202	66	83	22	67.4	12.6
Kansas	380	125	1	127	60	60	3	66.4	15.8
Kentucky	810	200	5	333	92	131	44	66.4	11.4
Louisiana	1,036	288	6	397	167	151	26	66.7	16.1
Maine	371	154	(1)	138	33	38	8	78.8	8.9
Maryland	936	295	1	351	158	112	19	69.1	16.9

TABLE 14.—MEDICAID EXPENDITURES BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1989—Continued

[In millions]

State	Total expenditure	Aged	Blind	Disabled	AFDC children	AFDC adults	Other title XIX	Aged, blind and disabled as a percent of total exp.	AFDC children as a percent of total exp.
Massachusetts	2,393	1,024	58	863	169	205	74	81.3	7.1
Michigan	1,954	413	6	795	311	350	79	62.1	15.9
Minnesota	1,105	332	6	429	79	224	36	69.4	7.1
Mississippi	474	149	3	162	56	80	25	66.2	11.8
Missouri	781	291	3	272	104	79	32	72.5	13.3
Montana	155	51	(¹)	54	17	20	7	67.7	11.0
Nebraska	256	96	1	83	28	29	19	70.3	10.9
Nevada	105	30	2	45	12	13	3	73.3	11.4
New Hampshire	183	98	4	64	6	10	(¹)	90.7	3.3
New Jersey	1,920	694	6	753	191	236	5	75.7	9.9
New Mexico	235	60	2	91	37	40	4	65.1	15.7
New York	10,191	4,419	82	3,690	1,020	832	148	80.4	10.0
North Carolina	1,165	383	6	406	178	153	38	68.2	15.3
North Dakota	178	66	(¹)	77	15	15	5	80.3	8.4
Ohio	2,666	804	8	957	494	358	45	66.4	18.5
Oklahoma	635	203	1	199	103	57	71	63.5	16.2
Oregon	409	118	11	152	60	68	0	68.7	14.7
Pennsylvania	2,458	913	3	826	422	246	48	70.9	17.2
Rhode Island	374	146	2	170	28	26	2	85.0	7.5
South Carolina	556	153	4	258	68	74	(¹)	74.6	12.2

South Dakota	143	55	1	60	16	11	0	80.8	11.2
Tennessee	972	266	5	358	178	139	26	64.7	18.3
Texas	2,226	803	14	734	303	371	2	69.7	13.6
Utah	201	38	(1)	81	26	45	10	59.2	12.9
Vermont	133	49	(1)	54	13	16	(1)	77.4	9.8
Virginia	822	323	4	299	98	97	0	76.2	11.9
Washington	962	294	1	361	139	159	8	68.2	14.4
West Virginia	324	98	1	100	37	86	3	61.3	11.4
Wisconsin	1,119	451	7	446	109	90	16	80.8	9.7
Wyoming	55	23	(1)	12	8	11	1	63.6	14.5
Puerto Rico	142	0	(1)	7	48	33	54	4.9	33.8
Virgin Islands	4	1	(1)	1	1	1	(1)	50.0	25.0
All jurisdictions	[2] 54,500	18,558	409	20,476	6,892	6,897	1,137	72.4	12.6
United States	54,354	18,558	409	20,468	6,843	6,862	1,082	72.6	12.6

---

[1] Denotes expenditures of less than $500,000.

[2] Some of the reasons that this figure is lower than that of table 11's 1989 total of $61,246 million are the following: the $54,500 figure does not include capitation premium payments, the State of Arizona or the smaller territories.

Note: Total expenditures include unknowns which are not reflected in this table.

Source: HCFA, BDMS, Office of Statistics and Data Management, Division of Medicaid Statistics.

TABLE 15.—TOTAL AND PER CAPITA MEDICAID PAYMENTS FOR CATEGORICALLY NEEDY AND MEDICALLY NEEDY, PRELIMINARY ESTIMATES, FISCAL YEARS 1975, 1981, AND 1989

	1975			1981			1989		Real percent change 1975–89	
	Total amount (millions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	Percent of total	Per capita amount	Total spending	Per capita
Categorically needy:										
Receiving cash payments	$7,188	58.7	$431	$14,534	53.4	$861	49.4	$1,650	58.3	61.8
Aged	1,341	11.0	555	2,480	9.1	1,270	8.2	2,866	41.1	118.2
Blind	61	.5	717	109	.4	1,527	.5	3,515	73.2	107.1
Disabled	2,042	16.7	1,094	5,616	20.6	2,490	22.5	4,543	153.5	75.5
AFDC children	1,850	15.1	222	3,002	11.0	361	9.1	624	13.1	18.8
Adults in AFDC families	1,895	15.5	478	3,328	12.2	769	9.2	1,224	11.3	8.2
Not receiving cash payments	1,753	14.3	1,261	4,736	17.4	2,641	20.7	3,496	171.8	17.1
Aged	1,275	10.4	2,331	3,143	11.6	5,273	10.4	8,439	88.7	53.0
Blind	12	.1	1,094	19	.1	2,785	.1	10,754	104.2	315.3
Disabled	353	2.9	1,854	1,214	4.5	5,146	6.6	9,472	330.9	115.9
AFDC children	61	.5	152	153	.6	302	1.2	643	364.1	78.7
Adults in AFDC families	27	.2	144	87	.3	298	1.2	984	942.2	188.7
Other title XIX	25	.2	463	120	.4	734	1.1	1,289	893.7	17.6
Total, categorically needy	8,941	73.0	495	19,270	70.8	1,032	70.1	1,955	80.5	66.9

Medically needy:										
Aged	1,742	14.2	2,672	4,303	15.8	5,260	13.6	10,328	80.2	63.3
Blind	20	.2	1,472	27	.1	3,132	0.1	16,247	20.4	366.3
Disabled	657	5.4	2,202	2,471	9.1	4,924	7.6	12,003	167.0	130.3
AFDC children	274	2.2	324	353	1.3	460	1.7	909	44.2	18.5
Adults in AFDC families	140	1.1	368	348	1.3	613	1.4	1,169	136.0	34.2
Other title XIX	467	3.8	267	433	1.6	360	0.9	714	−56.9	13.5
Total, medically needy	3,301	27.0	838	7,935	29.2	2,145	25.4	4,031	77.0	103.2
Grand total	12,242	100.0	556	27,205	100.0	1,216	100.0	2,318	88.1	76.1

---

[1] Note: Totals may not add due to rounding. Fiscal year 1975 ends in June; fiscal years 1981 and 1988 end in September. Real percentage change calculations reflect an adjustment of the spending amounts by the Consumer Price Index (CPI–U).

TABLE 16.—MEDICAID RECIPIENTS AND PAYMENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1989

	Amount (in millions)	Percent of total	Recipients (in thousands) [1]	Percent of total	Per capita payments
Age 65 and over	$18,558.3	34.1	3,131.6	13.8	$5,926.1
Blind	409.4	.8	94.8	.4	4,318.6
Disabled	20,476.1	37.6	3,495.6	14.9	5,857.7
Dependent children under age 21	6,891.9	12.6	10,318.2	43.9	667.9
Adults in families with dependent children	6,896.5	12.7	5,717.4	24.3	1,206.2
Other title XIX	1,136.7	2.1	1,175.1	5.0	967.3
Total	54,500.2	100.0	23,510.7	100.0	2,318.1

[1] Total recipients are unduplicated. A small number of recipients are in more than one category during the year.

Note: Data exclude Unknowns.

Source: HCFA, BDMS, OSDM, Division of Medicaid Statistics.

TABLE 17.—MEDICAID PAYMENTS AND PER CAPITA PAYMENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1975 AND 1981–89

[Amounts in millions]

	1975	1981	1982	1983	1984	1985	1986	1987	1988	1989	Percent change, 1975–89
						In Nominal Dollars					
Payments:											
Age 65 and over	$4,358	$9,926	$10,739	$11,954	$12,815	$14,096	$15,097	$16,037	$17,135	$18,558	325.8
Blind	93	154	172	183	219	249	277	309	344	409	339.8
Disabled	3,052	9,301	10,233	11,184	11,758	13,203	14,635	16,507	18,250	20,476	570.9
Dependent children under age 21	2,186	3,508	3,473	3,836	3,979	4,414	5,135	5,508	5,848	6,892	215.3
Adults in families with dependent children	2,062	3,763	4,093	4,487	4,420	4,746	4,880	5,592	5,883	6,897	234.5
Other title XIX	492	552	689	747	700	798	980	1,078	1,198	1,137	131.1
Total [1]	12,242	27,204	29,399	32,391	33,891	37,508	41,005	45,050	48,710	54,500	345.2
Per Capita Payment:											
Age 65 and over	1,205	2,948	3,315	3,545	3,957	4,605	4,808	4,975	5,425	5,926	391.8
Blind	850	1,784	2,047	2,379	2,766	3,104	3,401	3,644	4,005	4,319	408.1
Disabled	1,296	3,108	3,646	3,932	4,149	4,496	4,721	5,008	5,366	5,858	352.0
Dependent children under age 21	228	366	363	402	411	452	512	542	583	668	193.0
Adults in families with dependent children	455	725	764	802	789	860	864	999	1,069	1,206	165.1
Other title XIX	273	405	480	662	590	658	719	761	891	967	254.2
Total, Per Capita Payment	556	1,238	1,361	1,503	1,569	1,719	1,821	1,949	2,126	2,318	316.9

TABLE 17.—MEDICAID PAYMENTS AND PER CAPITA PAYMENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1975 AND 1981–89—Continued

[Amounts in millions]

	1975	1981	1982	1983	1984	1985	1986	1987	1988	1989	Percent change, 1975–89
						In Constant 1990 Dollars					
Payments:											
Age 65 and over	10,836	14,381	14,499	15,584	16,041	17,032	17,790	18,377	18,847	19,481	79.8
Blind	231	223	232	239	274	301	326	354	378	429	85.7
Disabled	7,589	13,475	13,816	14,580	14,717	15,953	17,246	18,915	20,073	21,494	183.2
Dependent children under age 21	5,435	5,082	4,689	5,001	4,981	5,333	6,051	6,312	6,432	7,235	33.1
Adults in families with dependent children	5,127	5,452	5,526	5,849	5,533	5,734	5,751	6,408	6,471	7,240	41.2
Other title XIX	1,223	800	930	974	876	964	1,155	1,235	1,318	1,194	−2.4
Total [1]	30,440	39,414	39,692	42,226	42,421	45,319	48,321	51,623	53,577	57,209	87.9
Per Capita Payment:											
Age 65 and over	2,996	4,271	4,476	4,621	4,953	5,564	5,666	5,701	5,967	6,221	107.6
Blind	2,114	2,585	2,764	3,101	3,462	3,750	4,008	4,176	4,405	4,534	114.5
Disabled	3,222	4,503	4,922	5,126	5,193	5,432	5,563	5,739	5,902	6,149	90.8
Dependent children under age 21	567	530	490	524	514	546	603	621	641	701	23.7

Adults in families with dependent children.......	1,131	1,050	1,031	1,046	988	1,039	1,018	1,145	1,176	1,266	11.9
Other title XIX..................	679	587	648	863	739	795	847	872	980	1,015	49.5
Total, Per Capita Payment..................	1,382	1,794	1,837	1,959	1,964	2,077	2,146	2,233	2,338	2,433	76.0

---

[1] Data exclude Unknowns.

Note: All total spending amounts are in millions. Fiscal year 1975 ends in June; all other fiscal years end in September. Nominal dollars converted to constant dollars using CPI–U price index.

Source: HCFA, BDMS, OSDM, Division of Medicaid Statistics.

TABLE 18.—MEDICAID PAYMENTS BY SERVICE CATEGORY, FISCAL YEARS 1975, 1981, 1988, AND 1989

[In millions and in constant 1990 dollars]

	1975		1981		1988		1989		Real percent change 1975–89
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	
Inpatient hospital	$9,396	30.9	$11,693	29.7	$14,796	27.6	$15,586	27.2	65.9
General	8,389	27.6	10,423	26.4	13,283	24.8	14,043	24.5	67.4
Mental	1,007	3.3	1,271	3.2	1,512	2.8	1,543	2.7	53.2
Skilled nursing facilities	6,052	19.9	5,846	14.8	6,989	13.0	6.991	12.2	15.5
Intermediate care facilities	5,632	18.5	10,870	27.6	15,337	28.6	16,292	28.5	189.3
Facilities for mentally retarded	945	3.1	4,341	11.0	6,624	12.4	6,980	12.2	638.6
Other	4,687	15.4	6,530	16.6	8,715	16.3	9,312	16.3	98.7
Physician	3,046	10.0	3,044	7.7	3,248	6.1	3,577	6.3	17.4
Dental	843	2.8	787	2.0	635	1.2	523	0.9	−38.0
Other practitioner	316	1.0	330	0.8	312	0.6	333	0.6	5.4
Outpatient hospital	927	3.0	2,041	5.2	2,654	5.0	2.978	5.2	221.3
Clinic	967	3.2	540	1.4	1,215	2.3	1,311	2.3	35.6
Lab and X-ray	313	1.0	213	0.5	597	1.1	619	1.1	97.8
Home health	174	0.6	620	1.6	2,216	4.1	2,700	4.7	1,451.7
Prescribed drugs	2,026	6.7	2,224	5.6	3,623	6.8	3,872	6.8	91.1

Family planning	167	0.5	201	0.5	227	0.4	238	0.4	42.5
Early and periodic screening [1]	([1])	0.0	97	0.2	135	0.3	153	0.3	([1])
Rural health clinic [1]	([1])	0.0	6	0.0	16	0.0	23	0.0	([1])
Other	579	1.9	897	2.3	1,574	2.9	2,011	3.5	247.3
Total	30,440	100.0	39,414	100.0	53,577	100.0	57,209	100.0	87.9

[1] 1975 data not available.

Note: Totals may not add to rounding. Fiscal year 1975 ends in June; all other fiscal years end in September. Real Percentage change calculations reflect an adjustment of the spending amounts using the Consumer Price Index (CPI–U). Data exclude unknowns.

Source: HCFA, BDMS, OSDM, Division of Medicaid Statistics.

TABLE 19.—MEDICAID RECIPIENTS BY SERVICE CATEGORY, FOR FISCAL YEARS 1975, 1981, 1987, 1988, AND 1989

[In thousands]

	Fiscal year—				
	1975	1981	1987	1988	1989
Inpatient hospital:					
General	3,432	3,703	3,767	3,832	4,171
Mental	67	90	57	60	90
Skilled nursing facilities	630	623	572	579	564
Intermediate care facilities:					
Facilities for the mentally retarded	69	151	149	145	148
Other	682	762	849	866	888
Physician	15,198	14,403	15,373	15,265	15,686
Dental	3,944	5,173	5,131	5,072	4,214
Other Practitioner	2,673	3,582	3,542	3,480	3,555
Outpatient Hospital	7,437	10,018	10,979	10,533	11,344
Clinic	1,086	1,755	2,183	2,256	2,391
Laboratory & X ray	4,738	3,822	7,596	7,579	7,759
Home Health	343	402	609	569	609
Prescribed drugs	14,155	14,256	15,083	15,323	15,916
Family planning	1,217	1,473	1,652	1,525	1,564
Early and periodic screening	([1])	1,969	2,234	2,295	2,524
Rural health clinics	([1])	81	129	140	166
Other	2,911	2,344	3,594	4,166	4,583
Unduplicated Total	22,007	21,980	23,109	22,907	23,511

---

[1] 1975 data not available.

Source: HCFA, BDMS, OSDM, Division of Medicaid Statistics.

TABLE 20.—MEDICAID MEDICAL VENDOR PAYMENTS BY BASIS OF ELIGIBILITY AND TYPE OF SERVICE: FISCAL YEAR 1989

Type of service	Aged	Blind	Disabled	AFDC		Other title XIX	Total
				Children	Adults		
				[In millions of dollars]			
Inpatient hospital services	1,263.4	85.2	4,958.1	3,269.6	3,219.1	507.0	13,302.4
Mental hospital services for the aged	633.9	.3	55.8	2.6	3.1	.9	696.6
SNF/ICF mental health services for the aged	82.2	([1])	3.1	0	([1])	0	85.3
Inpatient psychiatric, age <22	.9	.4	191.4	278.4	6.7	204.7	682.5
Intermediate care facility for the mentally retarded	264.2	104.3	6,206.5	20.1	3.2	36.9	6,635.2
Intermediate care facility all other	7,377.3	29.9	1,411.9	1.1	39.6	.7	8,860.5
Skilled nursing facility	5,182.5	37.5	1,332.9	5.5	87.1	7.5	6,653.0
Phsician's services	272.0	27.4	865.1	949.9	1,185.6	101.3	3,401.3
Dental services	35.6	1.4	82.0	221.2	139.9	17.5	497.6
Other practitioners' services	44.7	1.9	106.0	77.3	76.8	9.4	316.1
Outpatient hospital services	180.8	16.9	944.7	793.1	795.2	103.6	2,834.3
Clinic services	77.4	8.1	703.8	239.9	180.1	38.0	1,247.3
Home health services	1,440.5	23.9	1,028.2	37.7	26.2	14.5	2,571.0
Family planning services	.3	.8	15.4	21.1	185.1	4.3	227.0
Lab and x-ray services	27.1	3.5	181.0	120.6	247.7	9.4	589.3
Prescribed drugs	1,282.0	30.5	1,509.7	342.9	494.1	27.5	3,686.7
Early and periodic screening	.3	.1	2.4	132.7	4.1	6.2	145.8
Rural health clinic services	.8	.1	3.6	9.3	7.9	.4	22.1
Other care	392.4	37.2	874.4	368.9	194.9	46.7	1,914.5
Unknown	.1	([1])	([1])	([1])	([1])	([1])	.1
Total	18,558.3	409.4	20,476.1	6,891.9	6,896.5	1,136.7	54,368.6

TABLE 20.—MEDICAID MEDICAL VENDOR PAYMENTS BY BASIS OF ELIGIBILITY AND TYPE OF SERVICE: FISCAL YEAR 1989—Continued

Type of service	Aged	Blind	Disabled	AFDC		Other title XIX	Total
				Children	Adults		
				[In percent]			
Inpatient hospital services	6.8	20.8	24.2	47.4	46.7	44.6	24.5
Mental hospital services for the aged	3.4	.1	.3	0	0	.1	1.3
SNF/ICF mental health services for the aged	.4	0	0	0	0	0	.2
Inpatient psychiatric, age <22	.1	.1	.9	4.0	.1	18.0	1.3
Intermediate care facility for the mentally retarded	1.4	25.5	30.3	.3	0	3.2	12.2
Intermediate care facility all other	39.8	7.3	6.9	0	.6	.1	16.3
Skilled nursing facility	27.9	9.2	6.5	.1	1.3	.7	12.2
Physician's services	1.5	6.7	4.2	13.8	17.2	8.9	6.3
Dental services	.2	.3	.4	3.2	2.0	1.5	.9
Other practitioners' services	.2	.5	.5	1.1	1.1	.8	.6
Outpatient hospital services	1.0	4.1	4.6	11.5	11.5	9.1	5.2
Clinic services	.4	2.0	3.4	3.5	2.6	3.3	2.3
Home health services	7.8	5.8	5.0	.5	.4	1.3	6.8
Family planning services	0	.2	.1	.3	2.7	.4	.4
Lab and x-ray services	.1	.9	.9	1.7	3.6	.8	1.1
Prescribed drugs	6.9	7.4	7.4	5.0	7.2	2.4	6.8
Early and periodic screening	0	0	0	1.9	.1	.5	.3
Rural health clinic services	0	0	0	.1	.1	0	0
Other care	2.1	9.1	4.3	5.4	2.8	4.1	3.5
Unknown	0	0	0	0	0	0	0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

---

[1] Denotes those payments of less than $50,000.

Source: HCFA, BDMS, Office of Statistics and Data Management Division of Medicaid statistics.

TABLE 21.—AVERAGE EXPENDITURE PER RECIPIENT BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1989

State	Total	Aged	Blind	Disabled	AFDC Children	AFDC Adults	Other title XIX
All jurisdictions	$2,318	$5,926	$4,317	$5,122	$663	$1,206	$967
United States	2,449	5,928	4,347	5,193	682	1,290	1,413
Alabama	1,584	2,693	1,937	2,621	384	1,051	1,250
Alaska	3,423	9,633	4,107	11,370	1,650	2,555	0
Arkansas	2,033	3,577	2,989	3,745	708	916	1,398
California	1,653	2,995	3,052	3,612	486	1,168	1,454
Colorado	2,370	4,398	18,760	6,721	599	928	3,369
Connecticut	4,501	11,166	7,359	8,575	675	1,378	3,115
Delaware	2,876	8,883	5,538	6,865	651	1,134	1,008
District of Columbia	2,478	9,742	3,311	4,953	433	725	140
Florida	2,184	5,401	2,676	4,042	751	1,179	1,335
Georgia	2,108	3,676	2,558	4,226	606	1,673	1,205
Hawaii	1,709	3,659	2,056	2,127	506	945	0
Idaho	2,863	6,533	3,735	7,642	748	1,148	1,835
Illinois	2,017	5,047	5,656	4,924	587	961	1,778
Indiana	3,703	8,417	5,463	9,725	959	1,870	217
Iowa	2,324	4,455	2,930	7,131	747	1,481	1,387
Kansas	2,149	5,363	3,826	6,278	723	1,213	3,138
Kentucky	1,881	3,859	2,564	3,153	607	1,254	1,718
Louisiana	1,967	3,289	3,184	5,150	663	1,439	2,389
Maine	3,027	7,753	2,286	6,456	694	1,326	1,562
Maryland	2,915	6,876	4,068	6,124	906	1,576	2,962
Massachusetts	4,109	9,772	7,193	6,980	817	1,635	1,821
Michigan	1,749	4,265	2,524	4,075	500	1,025	1,083
Minnesota	3,426	7,165	10,322	14,091	677	2,092	1,397
Mississippi	1,168	2,587	1,854	2,284	370	1,044	515
Missouri	1,924	4,624	2,821	4,155	644	914	1.141
Montana	2,535	7,412	4,914	5,660	698	1,302	2,983
Nebraska	2,357	5,744	5,513	6,725	664	1,192	1,433
Nevada	2,545	4,483	3,908	6,784	677	1,323	1,441
New Hampshire	5,079	11,482	13,718	12,492	650	807	3,339
New Jersey	3,602	9,899	5,096	8,967	798	1,966	3,192
New Mexico	2,073	4,647	4,785	4,339	789	1,571	1,979
New York	4,523	13,076	20,777	7,960	927	1,819	1,140
North Carolina	2,390	4,186	5,091	5,156	799	1,262	13,315
North Dakota	3,832	7,205	6,465	10,902	875	1,516	1,080
Ohio	2,351	7,811	5,002	6,948	873	1,291	927
Oklahoma	2,507	3,951	2,143	6,246	935	1,291	4,948
Oregon	1,917	5,310	10,311	6,304	579	1,101	0
Pennsylvania	2,233	6,620	2,243	4,350	660	940	680
Rhode Island	3,634	7,685	5,891	8,475	680	1,203	2,400
South Carolina	2,006	3,356	2,029	4,054	839	1,335	1,218
South Dakota	3,212	6,591	4,187	8,051	867	1,133	0
Tennessee	1,791	3,374	2,087	3,285	694	1,328	3,381

TABLE 21.—AVERAGE EXPENDITURE PER RECIPIENT BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1989—Continued

State	Total	Aged	Blind	Disabled	AFDC Children	AFDC Adults	Other title XIX
Texas	1,878	3,703	3,025	5,333	698	1,361	628
Utah	2,135	5,164	4,003	8,478	764	1,510	1,612
Vermont	2,490	5,007	2,508	6,961	571	1,199	1,501
Virginia	2,379	5,139	3,414	5,178	664	1,241	0
Washington	2,253	5,911	3,731	5,942	604	1,174	916
West Virginia	1,350	3,911	2,463	2,740	478	1,127	1,612
Wisconsin	2,784	6,340	5,631	5,744	545	819	2,084
Wyoming	1,774	4,725	3,561	4,372	613	720	747
Puerto Rico	109	0	213	118	109	83	133
Virgin Islands	342	637	924	908	187	412	230

Source: HCFA, BDMS, Office of Statistics and Data Management, Division of Medicaid Statistics.

TABLE 22.—OPTIONAL MEDICAID SERVICES AND NUMBER OF STATES [1] OFFERING EACH SERVICE AS OF OCTOBER, 1990

Service	States offering service to categorically needy only	States offering service to both categorically and medically needy	Total
Podiatrists' services	13	33	46
Optometrists' services	15	36	51
Chiropractors' services	7	21	28
Other practitioners' services	13	31	44
Private duty nursing	7	20	27
Clinic services	16	39	55
Dental services	13	35	48
Physical therapy	10	31	41
Occupational therapy	6	24	30
Speech, hearing and language disorder	9	28	37
Prescribed drugs	17	37	54
Dentures	9	31	40
Prosthetic devices	15	36	51
Eyeglasses	17	33	50
Diagnostic services	5	21	26
Screening services	4	16	20
Preventive services	3	19	22
Rehabilitative services	11	31	42
Services for age 65 or older in mental institution:			
A. Inpatient hospital services	16	24	40
B. SNF services	10	19	29
ICF services for mentally retarded	23	28	51
Inpatient psychiatric services for under age 21	11	27	38
Christian science nurses	1	3	4
Christian science sanitoria	5	10	15
SNF for under age 21	21	29	50
Emergency hospital services	16	27	43
Personal care services	10	18	28
Transportation services	16	36	52
Case management services	10	31	41
Hospice services	9	23	32
Respiratory care services	4	8	12

---

[1] Includes the territories. Thus the maximum number is 53.

Source: Health Care Financing Administration, Medicaid Bureau, Office of Intergovernmental Affairs.

FEDERAL HOUSING ASSISTANCE [18]

A number of Federal programs administered by the Department of Housing and Urban Development (HUD) and the Farmers Home Administration (FmHA) address the housing needs of lower-income households. Housing assistance has never been provided as an entitlement to all households that qualify for aid. Instead, each year the Congress has appropriated funds for a number of new commitments. Because these commitments generally run from 5 to 50 years, the appropriation is actually spent gradually, over many years. These additional commitments have expanded the pool of available aid, thus increasing the total number of households that can be served. They have also contributed to growth in Federal outlays in the past and have committed the Government to continuing expenditures for many years to come.

The number of additional commitments funded annually has been cut back in recent years, and the nature and mix of assistance programs has changed. These shifts have, in turn, affected the distribution of available aid. This subsection describes recent trends in the number and mix of new commitments, as well as trends in expenditures.

TRENDS IN FEDERAL HOUSING ASSISTANCE

The Federal Government has traditionally provided housing aid directly to lower-income households in the form of rental subsidies and mortgage-interest subsidies. Recent legislation, the 1990 Cranston-Gonzalez National Affordable Housing Act (hereafter referred to as the 1990 Housing Act), authorized a new, indirect approach in the form of housing block grants to State and local governments, which may use these funds for various housing assistance activities specified in the law. Over the past decade, both the number of households receiving aid and total federal expenditures have increased each year, but the growth in outstanding commitments has slowed significantly during the 1980s.

Types of housing assistance

A number of different housing assistance programs have evolved in response to changing housing policy objectives. The primary purpose of housing assistance has always been to improve housing quality and to reduce housing costs for lower-income households. Other goals have included promoting residential construction, expanding housing opportunities for disadvantaged groups and groups with special housing needs, promoting neighborhood preservation and revitalization, increasing homeownership, and, most recently, empowering the poor to become self-sufficient.

New housing programs have been developed over time because of shifting priorities among these objectives—as housing-related problems changed—and because of the relatively high federal costs associated with some approaches. Other programs have become inactive in that the Congress stopped appropriating funds for new assistance commitments through them. Because housing programs traditionally have involved multiyear contractual obligations, however, these so-called inactive programs continue to play an important role today by serving a large number of households through commitments for which funds were appropriated some time ago.

---

[18] This discussion draws directly from a CBO Study entitled "Current Housing Problems and Possible Federal Responses," December 1988. For this report, CBO has updated all figures with three additional years of data.

Traditional rental assistance.—Most Federal housing aid is now targeted to very-low-income renters through the rental assistance programs administered by HUD and the FmHA.[19] Rental assistance is provided through two basic approaches: (1) project-based aid, which is typically tied to projects specifically produced for lower-income households through new construction or substantial rehabilitation; and (2) household-based subsidies, which permit renters to choose standard housing units in the existing private housing stock. Some funding is also provided each year to modernize units built with federal aid.

Rental assistance programs generally reduce tenants' rent payments to a fixed percentage—currently 30 percent—of their income after certain deductions, with the Government paying the remaining portion of the contract rents.

Almost all project-based aid is provided through production-oriented programs, which include the public housing program, the section 8 new construction and substantial rehabilitation program, and the section 236 mortgage-interest-subsidy program—all administered by HUD—and the section 515 mortgage-interest-subsidy program administered by the FmHA.[20] New commitments are being funded through three of the four—the public housing program, the section 8 new construction program, and the section 515 program. Under section 8, however, new aid is being provided only for elderly and handicapped households through the so-called section 202/8 program. Some assistance has also been funded annually under two small HUD programs authorized in 1983—the rental housing development grants (HoDAG) and the rental rehabilitation block grant programs.[21] These programs distribute funds through a national competition and by formula, respectively, to units of local government that meet eligibility criteria established by statute.

Some project-based aid is also provided through several components of HUD's section 8 existing-housing program, which tie subsidies to specific units in the existing-housing stock, many of which have received other forms of aid or mortgage insurance through HUD. These components—all of which are currently active—include the section 8 loan management set-aside (LMSA) and property disposition (PD) components, which are designed to improve cash flows in selected financially troubled projects that are or were insured by the Federal Housing Administration (FHA); the section 8 conversion assistance component, which subsidizes units that were previously aided through other programs; and the section 8 moderate rehabilitation program, which provides subsidies tied to units that are brought up to standard by the owner.[22]

---

[19] For more detailed description of the various types of programs, see Congressional Budget Office, *Federal Housing Assistance: Alternative Approaches* (May 1982); or National Association of Homebuilders, *Low- and Moderate-Income Housing: Progress, Problems and Prospects* (Washington, D.C.: NAHB, 1986); or Congressional Research Service, *Urban Housing Assistance Programs in the United States*. 89-137E (March 2, 1989).

[20] A small number of renters continue to receive project-based subsidies through the now inactive section 221(d)(3) below-market interest rate (BMIR) and rent supplement programs.

[21] The Housing and Community Development Act of 1987 terminated the HoDAG program at the end of fiscal year 1989, and the 1990 Housing Act repeals the rental rehabilitation block grant program at the end of fiscal year 1991.

Household-based subsidies are provided through two other components of the section 8 existing-housing program—section 8 rental certificates and vouchers. These programs, both of which are currently active, tie aid to households, who choose standard units in the private housing stock. Certificate holders generally must occupy units whose rents at initial occupancy are within guidelines—the so-called fair market rents (FMRs)—established by HUD. Voucher recipients, however, are allowed to occupy units with rents above the HUD guidelines, provided that they pay the difference.

Traditional homeowners' assistance.—Each year, the Federal Government also assists some lower- and moderate-income households in becoming homeowners by making long-term commitments to reduce their mortgage interest.[23] Most of this aid has been provided through the section 502 program administered by the FmHA, which itself supplies mortgage loans at low interest rates roughly equal to the long-term Government borrowing rates. Many homebuyers, however, receive much deeper subsidies through the interest-credit component of this program, which reduces their effective interest rate to as low as 1 percent. A number of homebuyers have received aid through the section 235 program administered by HUD, which provides interest subsidies for mortgages financed by private lenders. New commitments are now being made only through the section 502 program, but a small number of homeowners continue to receive aid from prior commitments made under the section 235 program.[24] Both programs generally reduce mortgage payments, property taxes, and insurance costs to a fixed percentage of income, ranging from 20 percent for the FmHA program to 28 percent for the latest commitments made under the HUD program. Households with relatively low incomes would have to pay larger shares, however, since mortgage payments must cover a minimum interest rate—currently 1 percent and 4 percent for the FmHA and HUD programs, respectively.

New directions in housing assistance.—The 1990 Housing Act, enacted in November 1990, authorizes several new housing assistance approaches. The major initiatives of the 1990 act are: the HOME investment partnerships block grant program, the homeownership and opportunity for people everywhere (HOPE) program, and the national homeownership trust demonstration. No funds have yet been appropriated for the new programs, but the Administration has requested funds for 1992 and a supplemental appropriation for 1991 to begin implementing the HOME and HOPE programs. No funds have been requested for the homeownership trust demonstration.

---

[22] The 1990 Housing Act repeals the section 8 moderate rehabilitation program at the end of fiscal year 1991, except for single-room occupancy units for the homeless.

[23] In addition, a small number of very-low-income homeowners receive grants or loans each year from the FmHA for housing repairs.

[24] The Housing and Community Development Act of 1987 terminated the section 235 program at the end of fiscal year 1989.

The HOME investment partnerships program is designed to increase the supply of housing affordable to low-income families through the provision of Federal grants to State and local governments. Funds may be used for tenant-based rental assistance or for acquisition, rehabilitation or, in limited circumstances, construction of both rental and ownership housing. Participating jurisdiction must provide matching contribution for HOME funds—25 percent for funds used for rental assistance or light rehabilitation; 33 percent for funds used for substantial rehabilitation; and 50 percent for funds used for new construction.

The multifaceted homeownership and opportunity for people everywhere (HOPE) program is designed to increase homeownership opportunities among low-income households, to combine traditional housing assistance programs for certain elderly and homeless people with supportive services, and to preserve certain federally assisted rental housing units for low-income use. To increase homeownership opportunities, HOPE grants will be provided to private nonprofits, cooperatives, public agencies, and instrumentalities to enable low-income households to become owners of units in public and Indian housing and other multifamily or single-family properties that are owned or whose mortgages are held by various Federal agencies, State or local governments, or by the Resolution Trust Corporation. To enable elderly individuals to continue living independently, HOPE grants will be provided for supportive services, to be combined with vouchers for rental assistance. To address the needs of homeless individuals with mental illness, substance abuse problems, or AIDS, the shelter plus care component of HOPE will provide funds for section 8-like rental assistance, to be combined with supportive services funded at the State or local level. Finally, to address the potential loss of low-income rental housing projects whose owners are eligible to terminate the low-income use through prepaying their mortgages, HOPE will provide funds for incentives to owners not to prepay; to assist residents or other qualified organizations in purchasing the projects; and for vouchers to assist tenants adversely affected by prepayment.

The national homeownership trust demonstration is designed to lower the cost of ownership for moderate-income, first-time homebuyers by establishing a trust fund to help buy down the maximum mortgage interest rate on eligible properties to 6 percent. An eligible property would be a single-family residence or cooperative unit for which the mortgage amount does not exceed the limits established for FHA insurance.

Trends in commitments for housing assistance

Although the Federal Government has been subsidizing the shelter costs of lower-income households since 1937, more than half of all currently outstanding commitments were funded over the past 15 years. Between 1977 and 1991, about 2.5 million net new commitments were funded to aid lower-income renters. Another 0.9 million new commitments were provided in the form of mortgage assistance to lower- and moderate-income homebuyers. Between 1977 and 1983, the number of net new rental commitments funded each year declined steadily, however, from 375,000 to 78,000. Trends have been somewhat erratic since 1983. Over the 15-year period, commitments for new homebuyers generally decreased, ranging from a high of 140,000 in 1980 to a low of about 24,000 in 1987 (see table 23).

TABLE 23.—NET NEW COMMITMENTS FOR RENTERS AND NEW COMMITMENTS FOR HOMEBUYERS, 1977–91

Fiscal year	Net new commitments for renters			New commitments for homebuyers
	Existing housing	New construction	Total	
1977	127,581	247,667	375,248	112,234
1978	126,472	214,503	340,975	112,214
1979	102,669	231,156	333,825	107,871
1980	58,402	155,001	213,403	140,564
1981	83,520	94,914	178,434	74,636
1982	37,818	48,157	85,975	66,711
1983	54,071	23,861	77,932	54,550
1984	78,648	36,719	115,367	44,409
1985	85,741	42,667	128,408	45,387
1986	85,476	34,375	119,851	25,479
1987	72,788	37,247	110,035	24,132
1988	65,295	36,456	101,751	26,200
1989	68,858	30,049	98,907	25,264
1990	61,309	23,491	84,800	24,968
1991 (estimate)	76,124	38,093	114,217	26,080

Source: Congressional Budget Office based on data provided by the Department of Housing and Urban Development and the Farmers Home Administration.

Note: Net new commitments for renters represent net additions to the available pool of rental aid and are defined as the total number of commitments for which new funds are appropriated in any year. To avoid double-counting, these numbers are adjusted for the number of commitments for which such funds are deobligated or canceled that year; the number of commitments for units converted from one type of assistance to another; in the FmHA Section 515 program, the number of units that receive more than one subsidy; starting in 1985, the number of commitments specifically designed to replace those lost because private owners of assisted housing opt out of the programs or because public housing units are demolished; and, starting in 1989, the number of commitments for units whose section 8 contracts expire.

New commitments for homebuyers are defined as the total number of new loans that the FmHA may make (or that HUD may subsidize) each year based on the maximum lending authority set by the Congress. This measure of program activity is meant to indicate how many new homebuyers can be helped each year and is therefore not adjusted to account for homeowners who leave the programs in any year because of mortgage repayments, prepayments, or foreclosures. Thus, it does not represent net additions to the total number of assisted homeowners and therefore cannot be added to net new commitments for renters.

The production-oriented approach in rental programs has been sharply curtailed in recent years in favor of the less costly section 8 existing-housing and voucher programs. Between 1977 and 1982, commitments through programs for new construction and substantial rehabilitation ranged annually from 53 percent to 73 percent of the total; since then, however, they have made up generally one-third or less of all additional rental commitments.

The relative emphasis on new construction compared with rental rehabilitation and repair programs has fluctuated over the years. Most recently, the Congress has shifted funding away from new construction in favor of rehabilitation. For example, annual appropriations since 1987 included more than twice as much funding for modernization of public housing projects compared with 1986, while the annual funding levels for additional newly constructed units since 1989 are below the 1986 level.

The total number of households receiving assistance has increased substantially, from 3.2 million at the beginning of fiscal year 1977 to 5.6 million at the beginning of fiscal year 1991—a 77 percent increase (see table 24). This increase results largely from net new commitments over the past 15 years, but also from commitments made before 1977 that have been processed during this period. The number of households receiving rental subsidies increased from 2.1 million to 4.6 million, while the number of homeowners receiving assistance in a given year has fluctuated between 1.0 million and 1.2 million, with a steady decline since 1983. The latter pattern reflects commitments for newly assisted households being more than offset by loan repayments, prepayments, and foreclosures among previously assisted households. Thus, the proportion of all assisted households that receives homeownership assistance has declined from 34 percent at the beginning of 1977 to 18 percent at the beginning of 1991. Among rental assistance programs, the shift away from production-oriented programs toward existing housing is reflected in the increasing proportion of renters receiving aid through the latter approach, from 13 percent at the beginning of fiscal year 1977 to 36 percent at the beginning of 1991, with the proportion of renters receiving household-based subsidies increasing from 8 percent to 25 percent.

TABLE 24.—TOTAL HOUSEHOLDS RECEIVING ASSISTANCE BY TYPE OF SUBSIDY, 1977–91

[Households in thousands]

	Assisted renters					Total assisted homeowners	Total assisted homeowners and renters
	Existing housing			New construction	Total assisted renters		
	Household based	Project based	Subtotal				
Beginning of fiscal year:							
1977	162	105	268	1,825	2,092	1,071	3,164
1978	297	126	423	1,977	2,400	1,082	3,482
1979	427	175	602	2,052	2,654	1,095	3,749
1980	521	185	707	2,189	2,895	1,112	4,007
1981	599	221	820	2,379	3,012	1,127	4,139
1982	651	194	844	2,559	3,210	1,201	4,411
1983	691	265	955	2,702	3,443	1,226	4,668
1984	728	357	1,086	2,836	3,700	1,219	4,920
1985	749	431	1,180	2,931	3,887	1,193	5,080
1986	797	456	1,253	2,986	3,998	1,176	5,174
1987	893	473	1,366	3,047	4,175	1,126	5,301
1988	956	490	1,446	3,085	4,296	1,059	5,354
1989	1,025	509	1,534	3,117	4,402	1,033	5,436
1990	1,090	527	1,616	3,141	4,515	1,016	5,531
1991	1,137	540	1,678	3,180	4,613	993	5,606

Source: Congressional Budget Office based on data provided by the Department of Housing and Urban Development and the Farmers Home Administration.

Note: Figures for total assisted renters have been adjusted since 1980 to avoid double-counting households receiving more than one subsidy.

BUDGET AUTHORITY AND OUTLAYS FOR HOUSING ASSISTANCE

Funding for most additional commitments for housing assistance is provided each year through appropriations of long-term budget authority for subsidies to households and through appropriations of budget authority for grants and direct loans to public housing agencies, homebuyers, and developers of rental housing.

Annual appropriations of new budget authority for housing assistance have been cut dramatically during the 1980s. These cuts reflect four underlying factors: the previously mentioned reduction in the number of newly assisted households; the shift toward cheaper existing-housing assistance; a systematic reduction in the average term of new commitments from more than 24 years in 1977 to about 7 years in 1991; and, since 1987, the change in the method for financing the construction and modernization of public housing.[25] For HUD's programs alone, appropriations of budget authority declined (in 1990 dollars) from a high of $59 billion in 1978 to a low of $9.2 billion in 1989 (see table 25). The increased levels of budget authority in 1990 and 1991 reflect for a large part the cost of renewing expiring section 8 contracts. Similarly, new lending authority for FmHA's direct loan programs decreased (in 1990 dollars) from a high of $6.4 billion in 1979 to $1.9 billion in 1991.

---

[25] Before 1987, new commitments for the construction and modernization of public housing were financed over periods ranging from 20 to 40 years, with the appropriations for budget authority reflecting both the principal and interest payments for this debt. Starting in 1987, these activities are financed with up-front grants, which reduces their budget authority requirements by between 51 percent and 67 percent.

TABLE 25.—NET BUDGET AUTHORITY APPROPRIATED FOR HOUSING AID, ADMINISTERED BY HUD, 1977–91

[In millions of current and 1990 dollars]

Fiscal year	Net budget authority	
	Current dollars	1990 dollars
1977	28,579	56,215
1978	32,169	59,137
1979	25,123	42,491
1980	27,435	42,660
1981	26,022	36,797
1982	14,766	19,454
1983	10,001	12,651
1984	11,425	13,924
1985	11,071	13,087
1986	10,032	11,546
1987	8,979	10,030
1988	8,592	9,312
1989	8,879	9,236
1990	[1] 10,557	10,557
1991	[1] 19,460	18,645

[1] Includes $99 million, $1,164 million, and $7,735 million for renewing expiring section 8 contracts in 1989, 1990, and 1991, respectively.

Note: All figures are net of funding rescissions, exclude reappropriations of funds, but include supplemental appropriations. Totals include funds appropriated for public housing operating subsidies. Excludes budget authority for HUD's section 202 loan fund and for programs administered by the Farmers Home Administration.

Source: Congressional Budget Office, based on data provided by the Department of Housing and Urban Development.

On the other hand, with the continuing increase in the number of households served, total outlays (expenditures on behalf of all households actually receiving aid in a given year) for all housing assistance programs combined have risen steadily (in 1990 dollars), from $6.4 billion in fiscal year 1977 to $18.3 billion in fiscal year 1990, an increase of almost 190 percent (see table 26). Moreover, despite recent measures to contain costs, and the increase in household contributions from 25 percent to 30 percent of adjusted income, average Federal outlays per unit for all programs combined have generally continued to rise in real terms, from around $1,920 in 1977 to around $3,290 in 1990—an increase of more than 70 percent (see table 27).[26] Several factors have contributed to this

---

[26] The change in the method for financing the construction and modernization of public housing caused a large one-time expenditure in 1985, when most of the outstanding debt incurred since 1974 for construction and modernization was paid off (see table 26). Without that bulge in expenditures, average outlays per unit in 1985 would have been about $3,160 in 1990 dollars.

growth. First, the number of households that occupy units completed under the section 8 new construction program has risen. These recently constructed units require larger subsidies compared with the older units that were built some time ago under the mortgage-interest subsidy programs and the public housing program. Second, the share of households receiving less costly homeownership assistance has decreased. Third, housing aid is being targeted toward a poorer segment of the population, requiring larger subsidies per assisted household. Fourth, rents in assisted housing have probably risen faster than the income of assisted households, causing subsidies to rise faster than the inflation index used here—the gross national product (GNP) implicit price deflator.[27]

TABLE 26.—OUTLAYS FOR HOUSING AID, 1977–90

[In millions of current and 1990 dollars]

Fiscal year	Outlays	
	Current dollars	1990 dollars
1977	3,248	6,389
1978	3,914	7,196
1979	4,708	7,962
1980	5,971	9,284
1981	7,900	11,171
1982	9,437	12,433
1983	11,366	14,377
1984	13,249	16,147
1985	27,578	32,600
1986	14,870	17,115
1987	15,278	17,065
1988	16,511	17,894
1989	17,310	18,006
1990	18,310	18,310

Source: Congressional Budget Office based on data provided by the Department of Housing and Urban Development and the Farmers Home Administration.

Note: The bulge in outlays in 1985 is caused by a change in the method of financing public housing, which generated close to $14 billion in one-time expenditures. This amount paid off—all at once—the capital cost of public housing construction and modernization activities undertaken between 1974 and 1985, which otherwise would have been paid off over periods of up to 40 years. Because of this one-time expenditure, however, future outlays for public housing will be lower than they would have been otherwise.

---

[27] For example, between 1980 and 1989, the GNP implicit price deflator increased 47 percent. Over the same period, median household income of renters and the Consumer Price Index for residential rents increased by 67 percent and 64 percent, respectively, but the maximum rents allowed for section 8 existing-housing rental certificates—the so-called fair market rents—rose around 79 percent.

TABLE 27.—PER UNIT OUTLAYS FOR HOUSING AID, 1977–90

[In current and 1990 dollars]

Fiscal year	Per unit outlays	
	Current dollars	1990 dollars
1977	980	1,920
1978	1,080	1,990
1979	1,210	2,050
1980	1,470	2,280
1981	1,850	2,610
1982	2,080	2,740
1983	2,370	3,000
1984	2,650	3,230
1985	5,380	6,360
1986	2,840	3,270
1987	2,870	3,200
1988	3,060	3,320
1989	3,160	3,280
1990	3,290	3,290

Source: Congressional Budget Office based on data provided by the Department of Housing and Urban Development and the Farmers Home Administration.

Note: The peak in outlays per unit in 1985 of $6,360 is attributable to the bulge in 1985 expenditures associated with the change in the method for financing public housing. Without this change, outlays per unit would have amounted to around $3,160 in 1990 dollars.

SCHOOL LUNCH AND BREAKFAST PROGRAMS

The National School Lunch Program (NSLP) and the School Breakfast Program (SBP) provide Federal cash and commodity support to participating public and private schools and nonprofit residential institutions that serve meals to children. Each program has a three-tiered reimbursement system that allows children from households with incomes at or below 130 percent of the poverty line to receive free meals, permits children with incomes between 130 percent and 185 percent of poverty to receive meals at a reduced price, and provides a small subsidy for the meals of children with incomes above 185 percent of poverty.[28] Children in AFDC families are automatically eligible to receive free breakfast and lunch. An estimated 49.2 percent of households receiving AFDC also receive free or reduced-price meals.[29]

The NSLP provides subsidized lunches to children in most schools. During fiscal year 1990, the average daily participation was 24.1 million students, and just over 4 billion meals were served at a total Federal program cost of $3.82 billion (see table 28). In fiscal year 1990, 91,500 elementary and secondary schools participated in the NSLP. Over 41 million children were enrolled in these schools, and approximately 60 percent of these students participated in the program. Roughly half of the meals subsidized by the NSLP go to children from lower income families although nearly 90 percent of Federal funding is used for these children's lunches. In fiscal year 1990, 41 percent of the children receiving NSLP lunches received free lunches, 7 percent received reduced-price lunches, and the remaining 52 percent paid full price for their meals.

The SBP serves far fewer students than does the NSLP. In fiscal year 1990, the program had an average daily participation of 4.1 million students, with total Federal program costs of $594 million (see table 29). In fiscal year 1990, the program operated in 40,000 schools, or about 45 percent of the schools participating in the school lunch program. Just over 19 million children were enrolled in these schools, of whom 20 percent participated in the program. The SBP also differs from the NSLP in that most of the schools that offer the program are in low-income areas, and the children who participate in the program are predominantly from low- and moderate-income families. In fiscal year 1990, 87 percent of the SBP participants received free or reduced-price breakfasts.

---

[28] For example, in the 1989-1990 school year, the NSLP schools receive Federal reimbursements of 153.25, 113.25 and 14.75 cents, respectively, for each lunch served to children from these three income categories. An additional 13.25 cents worth of commodity assistance is mandated for all lunches, regardless of the family income of the recipient. The corresponding levels of Federal reimbursement in the SBP are 86.0, 56.0 and 17.5 cents. Rates are 16 cents higher for free and reduced-price breakfasts served in schools meeting certain "severe need" criteria. Commodity assistance valued at 3 cents per breakfast is offered if USDA supplies are available.

[29] Other programs that provide nutritional assistance to children include the Child Care Food Program, the Summer Food Service Program, and the Special Milk Program.

TABLE 28.—THE NATIONAL SCHOOL LUNCH PROGRAM: PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–90

[Dollars in millions]

Fiscal year	Participation 9 month average (in millions) [1]				Federal costs [4]	Federal costs in constant 1990 dollars
	Free meals	Reduced-price meals	Full-price meals [2]	Total [3]		
1977	10.5	1.3	14.5	26.3	$2,111.1	$4,554.6
1978	10.3	1.5	14.9	26.7	2,293.6	4,623.1
1979	10.0	1.7	15.3	27.0	2,659.0	4,864.8
1980	10.0	1.9	14.7	26.6	3,051.9	4,913.6
1981	10.6	1.9	13.3	25.8	2,959.5	4,287.8
1982	9.8	1.6	11.5	22.9	2,611.5	3,525.8
1983	10.3	1.5	11.2	23.0	2,835.5	3,696.5
1984	10.3	1.5	11.5	23.4	2,953.5	3,696.9
1985	9.9	1.6	12.1	23.6	3,045.1	3,679.3
1986	10.0	1.6	12.2	23.7	3,172.6	3,738.6
1987	10.0	1.6	12.4	24.0	3,315.9	3,799.7
1988	9.8	1.6	12.8	24.2	3,249.7	3,574.4
1989	9.8	1.6	12.7	24.1	3,554.6	3,731.3
1990	9.7	1.6	12.8	24.2	3,818.6	3,818.6

[1] In order to reflect participation for the actual school year (September through May), these estimates are based on 9 month averages of October through May, plus September, rather than averages of the 12 months of the fiscal year (October through September).

[2] The Federal Government provides a small subsidy for these meals.

[3] Details may not sum to total because of rounding.

[4] Includes cash payments and entitlement commodities, does not include the value of bonus commodities.

Note: Constant dollars were calculated using the fiscal year CPI–U.

Sources: U.S. Department of Agriculture, Food and Nutrition Service, "Annual Historical Review of FNS Programs: Fiscal Year 1986" and U.S. Department of Agriculture, Food and Nutrition Service, "Food Program Update fiscal year 1990 (January 1991).

TABLE 29.—THE SCHOOL BREAKFAST PROGRAM: PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–90

[Dollars in millions]

Fiscal year	Participation 9 month average (in millions) [1]				Federal costs	Federal costs in constant 1990 dollars
	Free meals	Reduced-price meals	Full-price meals [2]	Total [3]		
1977	2.0	0.1	0.4	2.5	$148.6	$320.6
1978	2.2	.2	.4	2.8	181.2	365.2
1979	2.6	.2	.5	3.3	231.0	422.6
1980	2.8	.3	.6	3.6	287.8	463.4
1981	3.1	.3	.5	3.8	331.7	480.6
1982	2.8	.2	.4	3.3	317.3	428.4
1983	2.9	.2	.3	3.4	343.8	448.2
1984	2.9	.2	.4	3.4	364.0	455.6
1985	2.9	.2	.4	3.4	385.3	465.5
1986	2.9	.2	.4	3.5	412.0	485.5
1987	3.0	.2	.5	3.7	468.3	536.6
1988	3.0	.2	.5	3.7	473.2	520.5
1989	3.1	.2	.5	3.8	513.0	538.5
1990	3.3	.2	.5	4.0	594.0	594.0

---

[1] In order to reflect participation for the actual school year (September through May), these estimates are based on 9 month averages of October through May, plus September, rather than averages of the 12 months of the fiscal year (October through September).

[2] The Federal Government provides a small subsidy for these meals.

[3] Details may not sum to totals due to rounding.

Note: Constant dollars were calculated using the fiscal year CPI–U.

Sources: U.S. Department of Agriculture, Food and Nutrition Service, "Annual Historical Review of FNS Programs: Fiscal Year 1986," and U.S. Department of Agriculture, Food and Nutrition Service, "Food Program Update fiscal year 1990 (January 1991) Appendix (November 1987). USDA.

THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

The Special Supplemental Food Program for Women, Infants, and Children (WIC) provides food assistance and nutritional screening to low-income pregnant and postpartum women and their infants, as well as to low-income children up to age 5. Participants in the program must have incomes at or below 185 percent of poverty, and must be nutritionally at risk.[30] Under the Child Nutrition Act of 1966, nutritional risk is defined as detectable abnormal nutritional conditions; documented nutritionally-related medical conditions; health-impairing dietary deficiencies; or conditions that predispose people to inadequate nutrition or nutritionally related medical problems.

WIC, which is federally funded, but administered by State and local agencies, does not serve all who are eligible. In fiscal year 1990, Federal costs totaled $2.1 billion and the program served approximately 4.5 million women, infants, and children (see table 30). In July of 1987, the USDA released a report of the WIC eligibility study ("Estimation of Eligibility for the WIC Program") which found that in 1984, an estimated 9.6 million persons were income-eligible for the WIC program, and 7.5 million of those were estimated to be at nutritional risk. Thus, 7.5 million persons were fully eligible for the WIC program at that time. Another USDA study released in April 1990 "Study of WIC Participant and Program Characteristics, 1988," indicated that in 1988 about two-thirds of WIC participants had incomes below the poverty level.

---

[30] Although States are free to set their upper income-eligibility limits between 100 percent and 185 percent of poverty, the majority (82 percent in 1985) use income cut-off levels of between 151 and 185 percent of poverty.

TABLE 30.—THE SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC): PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–90

[Dollars in millions]

Fiscal year	Participation (in thousands)				Federal costs [2]	Federal costs in constant 1990 dollars
	Women	Infants	Children	Total [1]		
1977	165.0	213.0	471.0	848.0	$255.9	$552.1
1978	240.0	308.0	633.0	1,181.0	379.6	765.1
1979	312.0	389.0	782.0	1,483.0	525.4	961.2
1980	411.0	507.0	995.0	1,913.0	724.7	1,166.8
1981	446.0	585.0	1,088.0	2,119.0	874.4	1,266.8
1982	478.0	623.0	1,088.0	2,189.0	948.2	1,280.2
1983	542.0	730.0	1,265.0	2,537.0	1,123.1	1,464.1
1984	657.0	825.0	1,563.0	3,045.0	1,386.3	1,735.2
1985	665.0	874.0	1,600.0	3,138.0	1,488.9	1,799.0
1986	712.0	945.0	1,655.0	3,312.0	1,580.5	1,862.5
1987	751.0	1,019.0	1,660.0	3,429.0	1,663.6	1,906.3
1988	815.0	1,095.0	1,683.0	3,593.0	1,802.4	1,982.5
1989	951.8	1,259.6	1,907.0	4,118.4	1,929.4	2,025.3
1990	1,034.4	1,411.9	2,065.0	4,511.3	2,125.9	2,125.9

[1] Details may not sum to totals due to rounding.

[2] Includes funding for WIC studies, surveys, and pilot projects.

Note: Constant dollars were calculated using the fiscal year CPI–U.

Sources: U.S. Department of Agriculture, Food and Nutrition Service, "Annual Historical Review of FNS Programs: Fiscal Year 1986," and U.S. Department of Agriculture, Food and Nutrition Service, "Food Program Updates for Fiscal Year 1990" (January 1991).

JOB TRAINING PARTNERSHIP ACT

Title II-A of the Job Training Partnership Act of 1982 (JTPA) provides block grants to States to fund training and related services for economically disadvantaged youths and adults. These activities are administered by States and localities, which select participants and design projects within Federal guidelines.

The aid is intended to increase participants' future employment and earnings and reduce their dependence on welfare. Services authorized under title II-A include institutional and on-the-job training, job search assistance, counseling, and other work-related assistance. At least 90 percent of the participants must be economically disadvantaged, which is defined as being a member of a family whose total income for the 6-month period prior to application (exclusive of unemployment compensation, child support payments, and welfare payments) does not exceed the higher of the poverty line or 70 percent of the Bureau of Labor Statistics' lower living standard. Members of families receiving Aid to Families With Dependent Children (AFDC) or other cash welfare payments or food stamps are also defined as economically disadvantaged.

Of title II-A participants in program year 1989, 53 percent were white, 32 percent were black and 12 percent were Hispanic. One-quarter of title II-A participants in program year 1988 were younger than 19, 15 percent were between the ages of 19 and 21, and 60 percent were 22 years or older. Of participants who terminated during program year 1989, 61 percent entered employment, and the average hourly wage for terminees who entered employment was $5.29.

The act requires program operators to serve AFDC recipients at least in proportion to their share of the eligible population. Since the program was implemented in 1983, about one-fifth of the participants in activities authorized by title II-A were AFDC recipients at the time that they enrolled—21 percent for example in program year 1988 (July 1988–June 1989) and 22 percent in program year 1989 (July 1989–June 1990).

Among title II-A participants who were AFDC recipients at the time of enrollment in program year 1989, women comprised 81 percent of the total, as compared with 48 percent of title II-A participants who did not receive AFDC. Among AFDC recipients, 32 percent were school dropouts, compared with 28 percent of those JTPA participants who were not AFDC recipients. AFDC recipients were more likely to be placed in classroom training (49 percent) than non-AFDC recipients (32 percent), and were less likely to participate in on-job-training (13 percent) than non-AFDC recipients (24 percent). The average entered employment rate in program year 1989 for AFDC recipients in JTPA was 50 percent, compared with an average entered employment rate of 64 percent for those JTPA participants who did not receive AFDC. The average hourly starting wage for AFDC recipients entering employment was $5.18, compared with $5.32 for non-AFDC recipients.

In fiscal year 1991, almost $1.8 billion is expected to be spent for JTPA II-A grants, providing training and other services to about 721,000 new enrollees. Data on participation (new enrollees) and budget authority for recent fiscal years are provided in table 31 below. Under its predecessor, the Comprehensive Employment and Training Act (CETA), grants included funds for public service employment as well as training and were considerably larger.

TABLE 31.—JOB TRAINING PROGRAMS [1] FOR THE DISADVANTAGED: NEW ENROLLEES, FEDERAL APPROPRIATIONS AND OUTLAYS, FISCAL YEARS 1975–91

Fiscal year	New enrollees	Budget authority (millions)	Outlays (millions)	Budget authority in constant 1990 dollars	Outlays in constant 1990 dollars
1975	1,126,000	$1,580	$1,304	$3,755	$3,099
1976	1,250,000	1,580	1,697	3,515	3,775
1977	1,119,000	2,880	1,756	5,964	3,636
1978	965,000	1,880	2,378	3,658	4,627
1979	1,253,000	2,703	2,547	4,829	4,550
1980	1,208,000	3,205	3,236	5,154	5,203
1981	1,011,000	3,077	3,395	4,493	4,958
1982	(2)	1,594	2,277	2,175	3,107
1983	(2)	2,181	2,291	2,846	2,990
1984	739,000	1,886	1,333	2,361	1,669
1985	814,100	1,886	1,710	2,279	2,066
1986	827,400	1,783	1,911	2,101	2,252
1987	771,600	1,840	1,880	2,108	2,154
1988	705,500	1,810	1,902	1,991	2,092
1989	766,300	1,788	1,868	1,877	1,961
1990	773,000	1,745	1,803	1,745	1,803
1991	721,000	1,778	1,761	1,688	1,671

[1] Figures shown in years 1975 through 1983 are for training activities under the Comprehensive Employment and Training Act (CETA); public service employment under CETA is not included. Figures shown in years 1984 through 1990 are for activities under title II–A of the Job Training Partnership Act.

[2] Comparable figures are not available for these years.

Source: Employment and Training Administration, Department of Labor, Employment and Training Reports of the President, Job Training Quarterly Survey data, budget briefing documents.

Title II–B of JTPA authorizes a summer employment and training program for economically disadvantaged youngsters, aged 16–21. Under this program, 100 percent of participants must be economically disadvantaged (defined above), and services include a full range of remedial education, classroom and on-job-training, as well as work experience for which participants are paid minimum wage. The summer program is administered through the nationwide network of local service delivery areas.

In fiscal year 1991 (summer of 1992), $682.9 million is available for the summer program and is expected to serve approximately 523,000 individuals. The most recent Training and Employment Report of the Secretary of Labor indicates that, in the summer of 1987, 35 percent of title II–B enrollees were ages 14 and 15, and 65 percent were between the ages of 16 and 21. During that summer, 5 percent of enrollees were dropouts, while 84 percent were students and 11 percent were high school graduates. Black youth comprised 43 percent of summer enrollees in 1987, while 31 percent were white and 21 percent were Hispanic. The Labor Department further reports that 11 percent had limited English-speaking ability, and 12 percent of summer youth were handicapped.

Table 32 presents a funding and participation history of the summer program.

TABLE 32.—SUMMER YOUTH EMPLOYMENT PROGRAM: FEDERAL APPROPRIATIONS, OUTLAYS, AND PARTICIPATION LEVELS, FISCAL YEARS 1984–91[1]

[Dollars in millions]

	Appropriations	Outlays	Outlays (1990 dollars)	Participants
1984	$824.5	$583.8	$730.7	767,600
1985	724.5	776.3	938.0	785,000
1986	636.0	746.1	879.2	634,400
1987	750.0	722.7	828.1	722,900
1988	718.1	707.1	777.7	604,500
1989	709.4	697.4	732.1	632,700
1990	699.8	699.5	699.5	538,000
1991	682.9	696.5	661.1	523,000

[1] Because JTPA is an advance-funded program, appropriations for the summer youth program in a particular fiscal year are spent the following summer. For example, fiscal year 1984 appropriations were spent during the summer of 1985; fiscal year 1991 appropriations will be spent during the summer of 1992.

Source: Employment and Training Administration, Department of Labor, appropriations justifications documents.

Job Corps, authorized by title IV–B of JTPA, serves economically disadvantaged youth, ages 16–21, who demonstrate both the need for, and the ability to benefit from, an intensive and wide range of services provided in a residential setting. The program is administered directly by the Federal Government through contractors and currently operates at 107 centers around the country. Services include basic education, vocational skill training, work experience, counseling, health care, and other supportive services.

Labor Department data for fiscal year 1989 indicate that the typical Job Corps enrollee is an 18-year-old high school dropout who reads at the seventh grade level, is a minority, comes from an economically disadvantaged family, and has never held a full-time job. Specifically, about two-thirds of Job Corps enrollees are male, 53 percent are black, 30.5 percent are white, and 11.5 percent are Hispanic. Almost 84 percent are high school dropouts, and 75 percent have never worked full-time. Almost 40 percent of Job Corps enrollees come from families on public assistance, and the average annual family income of enrollees in fiscal year 1989 was $5,335.

The average length of stay for Job Corps enrollees in fiscal year 1989 was 7.3 months, and the Labor Department estimates that 59.3 percent of terminees entered employment after leaving the program, while 14.8 percent either continued their education or entered another training program, for a total positive termination rate in 1989 of 74.1 percent.

Table 33 provides a funding and participation history of Job Corps since 1982. The program was first authorized in the mid-

1960's by the Economic Opportunity Act and has been authorized under JTPA since 1982.

TABLE 33.—JOB CORPS: FEDERAL APPROPRIATIONS, OUTLAYS, AND PROGRAM CAPACITY (AVERAGE ENROLLMENT), FISCAL YEARS 1982–1991

[Dollars in millions]

	Appropriations	Outlays	Outlays (1990 dollars)	Capacity
1982	$589.6	$595.0	$811.8	40,544
1983	618.0	563.3	735.1	40,544
1984	599.2	580.6	726.7	40,544
1985	617.0	593.0	716.5	40,544
1986	612.5	594.5	700.6	40,544
1987	656.4	630.6	722.6	40,544
1988	716.1	688.5	757.3	40,544
1989	741.8	689.5	723.8	40,544
1990	802.6	739.6	739.6	39,660
1991	867.5	807.8	766.7	40,864

Source: Department of Labor budget documents, Job Corps in Brief, program year 1989.

HEAD START

Head Start began operating in 1965 under the general authority of the Economic Opportunity Act of 1964. Head Start provides a wide range of services to primarily low-income children, ages 0 to 5, and their families. Its goals are to improve the social competence, learning skills, and health and nutrition status of low-income children so that they can begin school on an equal basis with their more advantaged peers. The services provided include cognitive and language development, medical, dental, and mental health services (including screening and immunizations); and nutritional and social services. Parental involvement is extensive, through both volunteer participation and employment of parents as Head Start staff. Formal training and certification as child care workers is provided to some parents through the Child Development Associate program.

Head Start's eligibility guidelines require that at least 90 percent of the children served come from families with incomes at or below the poverty line. At least 10 percent of the enrollment slots in each State must be available for handicapped children. In fiscal year 1990, 548,470 children—about 23 percent of 3- to 5-year-old children living in poor families—were served in Head Start programs, at a total Federal cost of $1.5 billion. About 18 percent of those served were in full-day programs (6 hours per day). Approximately 50 percent of Head Start children were in families receiving AFDC benefits during the 1989-90 school year. About 70 percent of Head Start families had incomes below $9,000 in that year. Forty-five percent of the head of household in Head Start families were unemployed and 34 percent were employed full-time. More than half of all Head Start families—55 percent—were single-parent families and 41 percent were two-parent families. Table 34 provides historical data on participation in and funding of the Head Start program while table 35 provides characteristics of children enrolled in the program.

TABLE 34.—PROJECT HEAD START: PARTICIPATION AND FEDERAL FUNDING, FISCAL YEARS 1965-91

[Dollars in millions]

Fiscal year	Enrollment	Budget authority
1965 (summer only)	561,000	$96.4
1966	733,000	198.9
1967	681,400	349.2
1968	693,900	316.2
1969	663,600	333.9
1970	477,400	325.7
1971	397,500	360.0
1972	379,000	376.3
1973	379,000	400.7
1974	352,800	403.9
1975	349,000	403.9
1976	349,000	441.0

TABLE 34.—PROJECT HEAD START: PARTICIPATION AND FEDERAL FUNDING, FISCAL YEARS 1965–91—Continued

[Dollars in millions]

Fiscal year	Enrollment	Budget authority
1977	333,000	475.0
1978	391,400	625.0
1979	387,500	680.0
1980	376,300	735.0
1981	387,300	818.7
1982	395,800	911.7
1983	414,950	912.0
1984	442,140	995.8
1985	452,080	1,075.0
1986	451,732	1,040.0
1987	446,523	1,130.5
1988	448,464	1,206.3
1989	450,970	1,235.0
1990	548,470	[1] 1,552.0
1991	[2] 603,835	1,951.8

[1] After sequestration.

[2] Projected enrollment.

Note: Since 1982, only full year services have been provided.

TABLE 35.—CHARACTERISTICS OF CHILDREN ENROLLED IN HEAD START

[In percent]

Fiscal year	Age of children enrolled					Enrollment by race				
	Handicapped children	5 and older	4	3	Under 3	American Indian	Hispanic	Black	White	Asian
1980	11.9	21	55	24	0	4	19	42	34	1
1982	12.0	17	55	26	2	4	20	42	33	1
1984	11.9	16	56	26	2	4	20	42	33	1
1986	12.2	15	58	25	2	4	21	40	32	3
1988	12.7	11	63	23	3	4	22	39	32	3
1990	13.5	8	64	25	3	4	22	38	33	3

Source: Health and Human Services.

LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

The predecessor to the Low-Income Home Energy Assistance Program (LIHEAP) was created by Title III of the Crude Oil Windfall Profit Tax Act of 1980 (P.L. 96-223). The purpose of LIHEAP is to help low-income households meet their energy-related expenses. In fiscal year 1981, $1.85 billion was appropriated for the program.

In 1981, title XXVI of the Omnibus Budget Reconciliation Act (OBRA) (Public Law 97-35), the Low-Income Home Energy Assistance Act of 1981, authorized the Secretary of Health and Human Services to make LIHEAP allotments to States for fiscal years 1982-1984. The Act permitted States to provide three types of energy assistance. States can: (1) help eligible households pay their home heating or cooling bills, (2) use up to 15 percent of their LIHEAP allotment for low-cost weatherization, and (3) provide assistance to households during energy-related emergencies.

The Human Services Reauthorization Act of 1984 (Public Law 98-558) amended the Low-Income Home Energy Assistance Act of 1981 and authorized appropriations for fiscal years 1985 and 1986. Appropriations for fiscal years 1982, 1983, and 1984 were $1.875, $1.975, and $2.075 billion, respectively. Public Law 98-619 appropriated $2.1 billion for fiscal year 1985. Public Law 99-178 appropriated $2.1 billion for fiscal year 1986.[31]

The Human Services Reauthorization Act of 1986, Public Law 99-425, amended the Act and extended the appropriations authorization through fiscal year 1990. Authorized appropriations levels are: $2.050 billion for fiscal year 1987; $2.132 billion for fiscal year 1988; $2.218 billion for fiscal year 1989; and $2.307 billion for fiscal year 1990. The appropriations for fiscal years 1987, 1988, 1989 and 1990 were $1.825 billion, $1.532 billion, $1.383 billion, and $1.393 billion, respectively.[32]

The Augustus F. Hawkins Human Services Reauthorization Act of 1990, Public Law 101-501, amended the act and extended the appropriations authorization through fiscal year 1994. Authorized appropriations levels are: $2.150 billion for fiscal year 1991; $2.230 billion for fiscal year 1992; and such sums as are necessary for fiscal years 1993 and 1994. The fiscal year 1991 appropriation is $1.610 billion, including a $195 million energy emergency "contingency fund" that was distributed to States in late January 1991 in response to large increases in home heating oil prices.

ALLOTMENTS TO STATES [33]

States may transfer up to 10 percent of their LIHEAP allotment to one or any combination of the block grants for community services, title XX social services, preventive health and health services, primary health care, and maternal and child health services. A State's decision to transfer part of its allotment to a block grant does not affect its subsequent fiscal year allotment. The maximum amount of LIHEAP funds that a State can carry over to the next fiscal year is 15 percent. This provision applies to a State's allotment after adjustments have been made for tribal set aside and transfers to block grants. States must explain why funds are held over until the next fiscal year and what types of assistance the funds will provide. The amount carried over does not affect the State's subsequent fiscal year allocation. Amounts above 15 percent that are not spent by the State must be reallocated by the Secretary of Health and Human Services. Special allotment and set-aside rules apply to grants for Indian tribes and the territories.

---

[31] The Balanced and Emergency Deficit Control Act of 1985, as reaffirmed by Public Law 99-366, required the cancellation of $90.3 million of fiscal year 1986 budget authority.

[32] Funding for Federal administration is not included beginning with fiscal year 1988; these funds are now appropriated through a separate budget account. The fiscal year 1989 appropriation for allotments to States and territories (and training and technical assistance) was reduced from $1.4 billion to $1.383 billion (1.2 percent) under the terms of Public Law 100-436.

[33] As the result of court settlements of oil price overcharges under the Emergency Petroleum Allocation Act of 1973, substantial additional funding has been made available to States to supplement Federal LIHEAP appropriations; in fiscal year 1990, an estimated $109 million of these supplemental funds were used for the LIHEAP.

Table 36 shows State allotments for 1981 and selected recent fiscal years, and table 37 illustrates number of households receiving benefits from the single largest program component, heating assistance, average heating benefits and total dollars spent on heating assistance.

Eligibility and Types of Assistance

States have considerable discretion to determine eligibility criteria for LIHEAP and the types of energy assistance to be provided. At State option, LIHEAP payments can be made to households, based on categorical eligibility, where one or more persons are receiving: Supplemental Security Income, Aid to Families with Dependent Children, Veterans' Pensions, or Dependency and Indemnity Compensation. States can also elect to make payments to households with incomes that are less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Individuals who are denied benefits are entitled to an administrative hearing, except with regard to weatherization programs. The term "household" is defined as any individual or group of individuals who are living together as one economic unit and for whom residential energy is customarily purchased in common, or who make undesignated payments for energy in the form of rent. States cannot establish an income eligibility ceiling that is below 110 percent of the poverty level. States also are prohibited from treating categorically eligible and income eligible households differently with respect to LIHEAP. Further, LIHEAP benefits cannot be used to calculate income or resources, or affect other benefits, under Federal or State law, including public assistance programs.

States are required to give assurances that the largest benefits go to those households that have the lowest income and highest energy costs relative to their income, taking into account family size. In addition, States are to conduct outreach activities aimed at making households with elderly or handicapped individuals aware that energy assistance is available. These outreach services may include: toll-free information hotlines, special application periods, transportation to LIHEAP application offices, and home visits. Section 607(a) of Public Law 98-558 directs the Department of Health and Human Services to collect annual data, including information on the number of LIHEAP households in which at least one household member is 60 years old or handicapped.

States also have considerable discretion in the methods they have available to provide assistance to eligible households. Methods that are used, vary by State and program. A list of methods that are used includes cash payments, vendor payments, two-party checks, vouchers/coupons, and payments directly to landlords. When paying home energy suppliers directly, States are required to give assurances that suppliers will charge the eligible households the difference between the amount of the assistance and the actual cost of home energy. Also, States may use Federal funds to provide tax credits to energy suppliers who supply home energy to low-income households at reduced rates.

Planning and Administration

States are required to submit an application for funds to the Secretary of Health and Human Services. As part of the annual application, the chief executive officer of the State is required to make several assurances related to eligibility requirements, anticipated use of funds, as well as to satisfy planning and administrative requirements. States are prohibited from using more than 10 percent of their total LIHEAP allotment for planning and administrative costs.

States must provide for public participation and public hearings in the development of the State plan, including making it, and any substantial revisions, available for public inspection and allowing public comment on the plan. Public Law 98-558 requires States to engage an independent person or organization to prepare an audit at least once every 2 years. However, the Single Audit Act of 1984 (P.L. 98-502) supersedes this requirement in most instances, and requires grantees to conduct an annual audit of all Federal financial assistance received. The law also contains two other related provisions. First, the Comptroller General is directed to evaluate, at least once every 3 years, whether a State's LIHEAP expenditures are consistent with law. Second, the Department of Health and Human Services is to develop regulations to prevent waste, fraud, and abuse in LIHEAP. (These regulations were published in final form on October 13, 1987.)

TABLE 36.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS

[In thousands of dollars]

States	Fiscal year—					
	1981 [1]	1985 [2]	1988 [2]	1989 [2]	1990 [2]	1991 [2]
Alabama	15,674	18,234	13,152	11,878	11,961	15,856
Alaska	7,505	7,247	8,395	7,582	7,635	9,594
Arizona	6,426	8,150	6,361	5,744	5,785	6,200
Arkansas	11,960	13,973	10,036	9,064	9,127	11,069
California	84,088	97,894	70,559	63,723	64,168	68,764
Colorado	29,319	33,299	24,602	22,218	22,373	23,419
Connecticut	38,247	43,440	32,094	28,984	29,187	35,541
Delaware	5,077	5,931	4,260	3,847	3,874	5,471
District of Columbia	5,940	6,940	4,984	4,501	4,533	5,269
Florida	25,921	28,970	20,811	18,795	18,926	21,731
Georgia	19,609	22,910	16,454	14,860	14,964	17,439
Hawaii	1,975	2,243	1,657	1,497	1,507	1,531
Idaho	11,181	12,877	9,596	8,667	8,727	9,493
Illinois	105,862	123,679	88,830	80,224	80,784	85,711
Indiana	47,431	55,371	40,220	36,323	36,577	41,069
Iowa	29,470	38,581	28,504	25,743	25,922	28,719
Kansas	15,515	18,211	13,090	11,822	11,905	12,901
Kentucky	24,943	29,141	20,930	18,902	19,034	22,537
Louisiana	16,024	18,867	13,446	12,144	12,228	13,203
Maine	27,513	27,914	20,792	18,777	18,908	23,550
Maryland	29,285	34,214	24,574	22,193	22,348	29,361
Massachusetts	82,707	86,878	64,198	57,979	58,383	69,364
Michigan	111,598	113,951	84,336	76,166	76,697	86,099
Minnesota	72,409	82,239	60,759	54,873	55,256	62,063
Mississippi	13,930	15,683	11,276	10,184	10,255	12,391
Missouri	37,885	48,026	35,482	32,045	32,268	35,779
Montana	11,350	12,298	11,256	10,165	10,236	10,938
Nebraska	13,799	19,032	14,096	12,731	12,820	13,851
Nevada	3,560	4,151	2,987	2,698	2,717	3,214
New Hampshire	14,481	16,447	12,151	10,974	11,051	13,648
New Jersey	71,025	82,849	59,598	53,824	54,200	66,929
New Mexico	8,867	9,973	7,963	7,192	7,242	8,123
New York	231,907	263,291	194,596	175,744	176,970	214,983
North Carolina	34,561	40,378	29,001	26,191	26,374	35,612
North Dakota	7,995	14,612	12,227	11,043	11,120	12,503
Ohio	93,651	109,413	78,583	70,970	71,465	78,365
Oklahoma	15,998	16,004	12,090	10,918	10,995	12,250
Oregon	22,723	25,808	19,067	17,220	17,340	19,298
Pennsylvania	124,568	141,479	104,527	94,400	95,059	107,475
Rhode Island	12,594	14,220	10,567	9,544	9,610	11,572

TABLE 36.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS—Continued

[In thousands of dollars]

States	Fiscal year—					
	1981 [1]	1985 [2]	1988 [2]	1989 [2]	1990 [2]	1991 [2]
South Carolina	13,822	14,544	10,446	9,434	9,500	12,451
South Dakota	10,241	11,434	9,931	8,969	9,031	10,691
Tennessee	25,267	29,520	21,202	19,148	19,281	21,652
Texas	41,261	48,206	34,623	31,268	31,487	36,455
Utah	13,289	14,827	11,432	10,325	10,397	11,062
Vermont	10,854	12,328	9,108	8,226	8,283	9,813
Virginia	39,019	41,677	29,934	27,034	27,222	36,051
Washington	33,104	40,896	31,363	28,325	28,522	31,495
West Virginia	16,507	19,285	13,851	12,509	12,596	13,676
Wisconsin	61,679	74,027	54,692	49,394	49,738	56,987
Wyoming	3,561	6,195	4,577	4,134	4,163	4,605
U.S. total	1,813,177	2,077,577	1,529,266	1,381,112	1,390,749	1,607,819

[1] Includes reallocation of funds and crisis intervention funds. Source: Low Income Energy Assistance Program; Report to Congress for Fiscal Year 1981; U.S. Department of Health and Human Services.

[2] Column does not add to total due to rounding. Source: U.S. Department of Health and Human Services.

Note: Includes payments to Indian tribal organizations. Excludes Federal administrative costs and payments to territories, approximately $5 million annually.

TABLE 37.—HEATING ASSISTANCE BENEFITS, NUMBER OF HOUSEHOLDS ASSISTED, AND AVERAGE BENEFIT BY STATE

[Fiscal year 1990]

State	Heating assistance benefits (in thousands) [1]	Estimated number of households assisted	Estimated average benefit (in dollars)
Total	$1,027,120	5,477,798	NA
Alabama	6,477	64,501	$101
Alaska	3,087	7,723	392
Arizona	[2] 4,734	[2] 34,302	[2] 138
Arkansas	6,077	63,531	96
California	[2] 37,460	[2] 530,331	[2] 69
Colorado	16,154	60,697	266
Connecticut	38,832	77,948	516
Delaware	3,512	11,383	321
District of Columbia	3,157	13,555	245
Florida	[2] 11,866	[2] 181,106	[2] 65
Georgia	11,417	63,782	179
Hawaii	[2] 1,178	[2] 5,359	[2] 180
Idaho	5,467	30,930	177
Illinois	54,007	143,564	376
Indiana	34,047	126,252	255
Iowa	18,191	90,712	174
Kansas	10,118	49,798	200
Kentucky	10,296	94,148	109
Louisiana	4,467	51,941	86
Maine	14,441	53,476	271
Maryland	21,224	78,898	269
Massachusetts	62,518	133,500	472
Michigan	34,900	231,000	151
Minnesota	39,800	107,115	371
Mississippi	4,069	40,686	100
Missouri	24,117	121,281	199
Montana	6,100	20,090	300
Nebraska	7,150	33,300	215
Nevada	2,023	11,782	172
New Hampshire	9,016	23,534	383
New Jersey	54,700	137,000	400
New Mexico	6,171	40,436	158
New York	148,309	721,013	206
North Carolina	17,346	160,351	108
North Dakota	7,167	16,679	430

TABLE 37.—HEATING ASSISTANCE BENEFITS, NUMBER OF HOUSEHOLDS ASSISTED, AND AVERAGE BENEFIT BY STATE—Continued

[Fiscal year 1990]

State	Heating assistance benefits (in thousands) [1]	Estimated number of households assisted	Estimated average benefit (in dollars)
Ohio	40,239	343,450	107
Oklahoma	7,458	85,770	87
Oregon	11,699	63,089	185
Pennsylvania	71,561	313,590	219
Rhode Island	9,059	22,791	364
South Carolina	6,889	76,543	90
South Dakota	5,999	19,757	304
Tennessee	12,796	63,980	200
Texas	16,634	415,904	38
Utah	7,666	38,662	198
Vermont	7,654	16,800	455
Virginia	30,685	112,579	270
Washington	15,478	72,199	214
West Virginia	6,785	60,109	113
Wisconsin	33,695	129,768	260
Wyoming	3,228	11,103	291

[1] State estimates of heating assistance obligations for fiscal year 1990 from the following available funds: fiscal year 1989 LIHEAP funds carried over for use in fiscal year 1990; "oil overcharge" funds made available by States for use in LIHEAP; Federal LIHEAP allotments (net of set-asides for Indian tribes); and any State or other funds made available for LIHEAP heating assistance.

[2] Benefits for heating and cooling assistance combined.

Source: U.S. Department of Health and Human Services, January 1991. Data compiled from telephone interviews with State offices conducted in September 1990.

VETERANS' BENEFITS AND SERVICES

The Department of Veterans Affairs (DVA) offers a wide range of benefits and services to eligible veterans, members of their families, and survivors of deceased veterans. The DVA programs include veterans compensation and veterans pensions—the main cash-assistance entitlement programs—readjustment and rehabilitation benefits, education and job training programs, medical care services, and the housing and loan guaranty programs. Also, the DVA provides life insurance, burial benefits, and special counseling and outreach programs. In fiscal year 1990, Federal outlays for veterans' benefits and services were $29.1 billion.

Veterans Compensation and Veterans Pensions

Service-connected compensation is paid to veterans who have incurred injuries or illnesses while in service. The amounts of the monthly payments are determined by disability ratings that are based on presumed average reductions in earnings capacities caused by the disabilities. Disability ratings generally range from 10 percent to 100 percent in 10-percent intervals; multiple injuries may result in combined-degree ratings, however, and some injuries are compensable at a zero-percent rating. Death compensation or dependency and indemnity compensation is paid to survivors of veterans who died as a result of service-connected causes. In 1990, about 2.2 million disabled veterans and 321,000 survivors received $11.7 billion in compensation payments.

Veterans pensions are means-tested cash benefits paid to war veterans who have become permanently and totally disabled from non-service-connected causes, and to survivors of war veterans. Under the current or "improved law" program, benefits are based on family sizes, and the pensions provide a floor of income: effective December 1, 1990, the basic benefit before subtracting other income sources is $9,343 for a veteran with one dependent ($7,133 for a veteran living alone). Somewhat less generous benefits are available to survivors; a surviving spouse with no children could receive two-thirds of the basic benefit amount given a single veteran. About 1.1 million persons received $4.0 billion in veterans pension payments in 1990.

Readjustment, Education, and Training Benefits

Several DVA programs support readjustment, education, and job training for veterans and military personnel who meet certain eligibility criteria. In 1990, the largest of these programs was the Montgomery GI bill (MGIB). The MGIB provides an entitlement to basic educational assistance to most persons who are, or have been, members of the Armed Forces or the Selected Reserve for specified periods of time after June 30, 1985. The purposes of the MGIB are to provide educational assistance to help in the readjustment to civilian life, to aid in recruitment and retention of qualified personnel in the Armed Forces, and to develop a more highly educated and productive work force.

Under the MGIB, contributions are required, and veterans can receive a basic educational benefit of up to $300 per month for 36 months while in an educational program.

The veterans' job training act program provides payments to defray training costs of employers who hire certain veterans of the Korean conflict or Vietnam era who have been unemployed for long periods of time.

Net outlays from the DVA account in 1990 for all education and training programs came to $493 million.

MEDICAL PROGRAMS

The DVA provides inpatient and outpatient medical and health-related services, and operates 172 hospital centers, 126 nursing homes, 32 domiciliaries, and 339 outpatient clinics. The DVA extends free priority care to service-connected disabled veterans, to veterans in special categories, and to needy nonservice-connected veterans—in 1991, those with incomes $21,805 or less if married with one dependent, plus $1,213 for each additional dependent, or $18,171 or less if single. Veterans eligible under these criteria are called "mandatory care" veterans, and they are entitled to hospital care. As facilities and other resources permit, the DVA provides care to non-service-connected veterans with incomes that exceed the mandatory care income limits. Medical care for these veterans requires copayments. DVA-operated nursing home care is augmented by DVA-supported care under contract in private community nursing homes and with per diem payments for veterans in State-run homes for veterans.

The DVA operates a nationwide health system. In 1990, the DVA received approximately 3.3 million applications for care; about 1.1 million hospital patients and 97,000 nursing home and domiciliary patients were treated in both DVA and non-DVA facilities; and 23.0 million outpatient visits were provided. Construction and modernization of facilities, as well as medical research and training programs, are also funded through DVA appropriations. In 1990, DVA medical programs cost the Federal Government $11.4 billion (see table 38).

TABLE 38.—EXPENDITURES AND NUMBER OF RECIPIENTS OF VETERANS BENEFITS AND SERVICES, FOR SELECTED FISCAL YEARS [1]

Fiscal year	Compensation and pensions	Readjustment, education, job training	Medical programs [2]	Housing loans
	Outlays (in billions of dollars)			
1975	7.4	4.6	3.7	(3)
1980	11.0	2.3	6.5	(3)
1981	12.2	2.3	7.0	(3)
1982	13.2	1.9	7.5	(3)
1983	13.7	1.6	8.3	(3)
1984	13.8	1.4	8.9	(3)
1985	14.1	1.1	9.5	(3)
1986	14.3	.5	9.9	(3)
1987	14.3	.5	10.3	(3)
1988	15.2	.5	10.8	(3)
1989	15.7	.5	11.3	(3)
	Recipients (in thousands)			
1975	4,855	2,804	1,985	290
1980	4,646	1,232	2,671	297
1981	4,535	1,074	2,765	188
1982	4,407	900	2,720	103
1983	4,286	755	2,933	245
1984	4,123	629	3,026	252
1985	4,005	491	2,963	179
1986	3,900	388	2,942	314
1987	3,850	312	2,900	479
1988	3,762	273	2,922	235
1989	3,686	330	3,344	190

---

[1] The major programs funded through the VA are included in the table; outlays for other, smaller programs, as well as general operating expenses, are not included. Outlays are net of receipts.

[2] Medical program expenditure data include outlays for direct medical services, medical research and training, and construction programs. Recipients are the number of applicants for all types of medical care during the year.

[3] No numbers are provided for expenditures under housing loans because these are revolving funds and are not comparable to program expenditures in the other columns.

Source: Department of Veterans Affairs.

HOUSING AND LOAN PROGRAMS

For loans closed between February 1, 1988, and December 17, 1989, the maximum VA loan guaranty operated as follows: (1) for loans of $45,000 or less, the guaranty amount was 50 percent of the loan, (2) for loans in excess of $45,000 the VA guaranty was the lesser of $36,000 or 40 percent of the loan amount, with a minimum guaranty of $22,500, (3) for manufactured homes the guaranty was 40 percent of the loan up to a maximum guaranty of $20,000. Public Law 101-237 provided that for loans closed on or after December 18, 1989, the maximum VA guaranty is as follows: (1) 50 percent of the loan amount for loans of $45,000 or less, (2) $22,500 for loans between $45,001 and $56,250, (3) the lesser of $36,000 or 40 percent of the loan for loans between $56,251 and $144,000, and (4) the lesser of $46,000 or 25 percent of the loan for loans in excess of $144,000. The VA expects to close about 161,000 guaranteed loans in fiscal year 1992.

A new Guaranty and Indemnity Fund (GIF) was created to fund the program. The Government must credit the GIF with: (1) for each VA guaranteed loan closed during fiscal year 1990, a fee of 0.375 percent of the original loan amount of the loan for each of fiscal years 1991 and 1992, and (2) for each loan closed after fiscal year 1990, a fee of 0.25 percent of the loan amount for the first 3 years of the loan.

The previous 1-percent loan guaranty fee was replaced with a 1.25 percent loan fee when the downpayment is less than 5 percent, a 0.75 percent loan fee when the downpayment is 5 to 9 percent, and a 0.50 percent loan fee when the downpayment is 10 percent or more. The Omnibus Budget Reconciliation Act of 1990 increased these funding fees by 0.625 percent during fiscal year 1991. On behalf of veterans who make downpayments of 10 percent or more, an amount equal to 0.25 percent of the loan is to be credited to the Guaranty and Indemnity Fund during the first 2 years of the loan. Persons who assume a VA guaranteed loan must pay a loan fee of 0.50 percent of the loan balance. Certain veterans with service-connected disabilities or their surviving spouses are exempt from paying the loan fees, but the GIF is required to be credited with amounts from Federal funds for the fees that would have been paid in the absence of the exemption. For loans closed after December 31, 1989, veterans are granted indemnity against further claims from the Government following a foreclosure, if there is no evidence of fraud and abuse.

TRENDS IN USE AND COSTS

Veterans programs are undergoing shifts in the demand for services as a result of changing demographics and eligibility. The veteran population as a whole is decreasing in numbers—from about 29.5 million in 1975 to 27.1 million in 1989—but the number of veterans age 65 or older is increasing rapidly—from about 2.2 million in 1975 to about 6.9 million in 1989 to an expected 7.1 million veterans by 1990. The use and cost of medical care, for example, are expected to grow more rapidly over the next several years than those of other veterans' benefits and services, unless constrained by discretionary appropriations. Compensation and pension caseloads are decreasing steadily due to beneficiary deaths, terminations for excess incomes, and age limitations for dependents. Participation under the Vietnam-era GI Bill has ceased since the program expired on December 31, 1989. However, as more veterans become eligible for the Montgomery GI bill, the number of trainees will increase.

Cost-of-living adjustments are usually appropriated for veterans' compensation payments, while improved-law veterans' pensions increase automatically each year at the same time and by the same percentage as Social Security benefits.

APPENDIX P. FEDERAL SOCIAL WELFARE PROGRAMS IN OUTLYING AREAS

The following table shows the outlying areas in which the major Federal social welfare programs are in effect and those areas in which they are not in effect.

The word "yes" in the column headed "covered" under each outlying area designates that Federal law permits the program to operate in that area. The column headed "special rules" notes whether the program operates in that area according to the same rules that apply in the States or according to different rules. The notes to the table explain the nature of any special rules.

The programs included in the table are:

- —Aid to families with dependent children (AFDC)
- —Aid to the aged, blind, or disabled (AABD)
- —Supplemental security income (SSI)
- —Food stamps
- —Medicaid
- —Medicare
- —Old-age, survivors, and disability insurance (OASDI)
- —Unemployment compensation
- —Earned income tax credit (EITC)
- —Maternal and child health (MCH) block grant
- —Title IV-B child welfare services
- —Title IV-E foster care and adoption assistance
- —Title XX social services
- —School lunch and school breakfast
- —Special supplemental food program for women, infants, and children (WIC)
- —Summer food service
- —Child care food

In general, extension of these programs to jurisdictions other than States requires that the law authorizing the program specify the area as eligible to participate. Thus, where the table indicates that the area is not covered ("no" under the column headed "covered"), the program cannot be implemented without a change in Federal law.

In some cases, a program is available to outlying areas by law, but the jurisdiction has not implemented it (these programs are noted by footnotes "2", "3" or "14"). In addition, all programs administered by the U.S. Department of Agriculture may be extended to outlying areas at the discretion of the Secretary of Agriculture, even though the area is not specifically mentioned in the authorizing legislation. (These programs are noted by footnote "7".) Where such programs have not been implemented, they could be if the Secretary were to authorize operation.

TABLE 1.—FEDERAL SOCIAL WELFARE PROGRAMS IN THE OUTLYING AREAS

Program	Puerto Rico		Virgin Islands		Guam		Northern Marianas		American Samoa		Marshall Islands and Micronesia		Palau	
	Covered	Special rules	Covered	Special rules	Covered	Special rules	Covered	Special rules	Covered	Special rules	Covered	Special rules	Covered	Special rules
AFDC	Yes	Yes [1]	Yes	Yes [1]	Yes	Yes [1]	Yes [2]	Yes [2]	Yes [3]	Yes [3]	No		No	
AABD	Yes	No	Yes	No	Yes	No	No [2]		No		No		No	
SSI	No		No		No		Yes	No	No		No		No	
Food stamps	No [4]		Yes	Yes [5]	Yes	Yes [5]	Yes	Yes [6]	No [7]		No [7]		No [7]	
Medicaid	Yes	Yes [6]	Yes	Yes [8]	Yes	Yes [8]	Yes	Yes [8]	Yes	Yes [8]	No		No	
Medicare	Yes	Yes [9]	Yes	Yes [10]	Yes	Yes [10]	Yes	Yes [10]	Yes	Yes [10]	No		No	
OASDI	Yes	No	Yes	No	Yes	No	Yes	No [11]	Yes	No	No		No	
Unemployment compensation	Yes	No	Yes	No	No		No		No		No		No	
EITC	No [12]		No [12]		No [12]		No [12]		No [12]		No [12]		No [12]	
Maternal/child health	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Child welfare	Yes	Yes [13]	Yes	Yes [13]	Yes	Yes [13]	Yes	Yes [13]	Yes	Yes [13]	No		No	
Foster care/adoption	Yes [14]	Yes [13]	Yes [14]	Yes [13]	Yes [14]	Yes [13]	Yes [14]	Yes [13]	Yes [3]	Yes [3]	No		No	
Social services	Yes	Yes [13]	Yes	Yes [13]	Yes	Yes [13]	Yes [14]	Yes [13]	Yes	Yes [13]	No		No	
School lunch/breakfast	Yes	Yes [16, 17]	Yes	Yes [16]	Yes	Yes [16]	Yes	Yes [16]	Yes	Yes [16]	No [7, 18]	No	Yes [15]	Yes
WIC	Yes	No	Yes	No	Yes	No	Yes [14]	No	Yes [14]	No	No [7]	No	Yes [14]	No
Summer food service	Yes [14]	No	Yes	No	Yes [14]	No	Yes [14]	No	Yes [14]	No	No [7, 18]	No	Yes [14]	Yes
Child care food	Yes [14]	No	Yes	No	Yes	No	Yes [14]	No	Yes [14]	No	No [7, 18]	No	Yes [14]	Yes

[1] The Federal matching rate is 75 percent rather than a rate based on per capita income. However, the Social Security Act sets a dollar maximum on Federal payments for AFDC, Emergency Assistance, AABD, and Foster Care and Adoption Assistance.

[2] The Northern Mariana Islands do not operate an AFDC or an AABD program. However, section 502 of P.L. 94-241 specifies that all Federal services and financial assistance programs applicable to Guam shall be applicable to the Northern Marianas. Nevertheless, this provision is irrelevant with respect to the AABD program because the Northern Marianas operate the SSI program which replaces AABD.

[3] Since October 1, 1988, jurisdiction has been eligible to participate, but has not implemented this program. If the program were implemented, the Federal matching rate would be 75 percent. However, the Social Security Act sets a dollar maximum on Federal payments for both AFDC and Foster Care and Adoption Assistance.

[4] Puerto Rico receives a block grant of Federal funds with which it operates a cash Nutrition Assistance program for needy households.

[5] The regular Food Stamp program operates in the Virgin Islands and Guam, except that benefit levels differ from those for the 48 contiguous States (recognizing substantially higher food prices), and the degree to which recipients' income is "disregarded" for excessively high nonfood living expenses differs from the 48 States (recognizing significant differences in these costs of living). Similar adjustments also are made for Alaska and Hawaii.

[6] Under the terms of the 1976 covenant with the Commonwealth, a variant of the regular Food Stamp program operates in the Northern Mariana Islands. The four basic differences from the regular Food Stamp program are: (1) Federal funding is limited to $3.7 million; (2) benefit levels are significantly higher than in the 48 contiguous States; (3) income eligibility limits are substantially lower than in the 48 States; and (4) a portion of each recipient's food stamp allotent (25 percent) must be used to purchase locally produced food (coupons for local food are differentiated by color).

[7] P.L. 96-597 (Sec. 601(c)) authorizes the Secretary of Agriculture to extend, at his discretion, the Food Stamp program (and other Agriculture Department programs) to American Samoa, the Federated States of Micronesia, the Marshall Islands, and Palau. If the Secretary chooses to extend the programs to territories, he may specify special rules for the program.

[8] The Federal matching rate is 50 percent rather than a rate based on per capita income, and Sec. 1108(c) of the Social Security Act sets a dollar maximum on Federal Medicaid payments to the territories.

[9] Hospital reimbursement rates under the prospective payment system in Puerto Rico are lower than in the States.

[10] Hospital prospective payment system in not applicable.

[11] Currently operating under transitional rules until coverage is complete.

[12] Some U.S. Government employees who are subject to the U.S. income tax while assigned to work in a U.S. territory might be eligible for EITC, but the general population would not be eligible.

[13] Special rules govern how funding allocations are made to these jurisdictions (or would govern if the jurisdiction elected to implement the program), as distinct from the way allocations are made to States.

[14] Jurisdiction is eligible to participate, but has chosen not to implement this program.

[15] Jurisdiction provides lunch only, not breakfast.

[16] Secretary is permitted to adjust average payment rates for meals to reflect differences in costs of providing meals from those in continental States.

[17] Definition of "school" includes nonprofit child care centers in Puerto Rico.

[18] National School Lunch Act programs were discontinued at the end of 1986 when the status of the Marshall Islands and Micronesia changed from "Trust Territories" to "Freely Associated States."

PART 2

TRUST FUNDS WITHIN THE REVENUE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS WHICH PROVIDE BENEFITS TO INDIVIDUALS

Section 1. Black Lung Disability Trust Fund
Section 2. Railroad Retirement System
Section 3. Railroad Unemployment Compensation System
Section 4. National Vaccine Compensation Trust Fund

Section 1. Black Lung Disability Trust Fund

LEGISLATIVE HISTORY AND JURISDICTION

National attention was focused on the working conditions of coal miners following a West Virginia coal mine accident in 1968 that killed 78 workers. Congressional hearings the following year on reform of the coal mine safety laws also examined the problems of coal workers' pneumoconiosis, or black lung disease. The Federal Coal Mine Health and Safety Act of 1969 established Federal minimum standards for mines in order to protect the safety and health of coal miners. In addition, title IV of the act provided benefits for miners totally disabled by black lung disease and for survivors and dependents of miners who had died from the disease or were totally disabled from the disease at death.

The 1969 act was the first effort, at any level of government, to provide benefits exclusively to the victims of a single occupational disease. This was also the first time the Federal Government took major responsibility in the traditionally State-administered area of workers' compensation. The 1969 act was amended by the Black Lung Benefits Act of 1972, the Black Lung Benefits Reform Act of 1977, the Black Lung Revenue Act of 1977, the Black Lung Benefits Revenue Act of 1981, and Public Law 99-272. Most recently Public Law 100-203 extended current coal excise tax rates through 2013.

The statutory provisions of the act as amended are contained in 30 U.S.C. sections 901 et seq. and in the Internal Revenue Code of 1954 sections 4121, 4218, 4952, 4953, and 9501, et seq.

There are two distinct programs of black lung benefits under title IV: part B and part C. The part B program is financed by Federal general revenues and is administered by the Social Security Administration (SSA). Benefits under part B are payable only for claims filed on or before June 30, 1973 (December 31, 1973, in the case of survivors), and thus no new beneficiaries can be added to the rolls. The part C program is administered by the Department of Labor (DOL) and generally applies to claims filed after June 30, 1973. Benefits under part C are paid either by the "responsible" coal mine operator or by the Black Lung Disability Trust Fund.

The Black Lung Disability Trust Fund was created in 1978 pursuant to the Black Lung Benefits Revenue Act of 1977 (Public Law 95-227). In 1981, the statutory provisions of the Black Lung Disability Trust Fund were transferred to the Internal Revenue Code by the Black Lung Benefits Revenue Act of 1981 (Public Law 97-119). The 1981 act, the 1986 Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272), and the 1987 Omnibus Budget Reconciliation Act (Public Law 100-203) revised provisions governing the Trust Fund's finance (i.e., excise tax rates on coal and interest on the debts owed by the Trust Fund).

The Committee on Ways and Means has jurisdiction over the excise tax on coal, the structure and administration of the Black Lung Disability Trust Fund, the expenditure purposes of the Trust Fund and tax provisions as to the coal mine operators' self-insurance trusts. The Committee on Education and Labor has jurisdiction over eligibility and evidentiary standards, claims adjudication, and related benefit provisions.

BENEFIT STRUCTURE

Generally, the Black Lung Disability Trust Fund ("Trust Fund") is required to pay benefits with respect to part C claims (claims filed *after* June 30, 1973) in which the miner's last coal mine employment was *before* January 1, 1970. Part B claims (claims filed on or *before* June 30, 1973) are generally paid by the Social Security Administration out of the general revenues of the Treasury, not the Trust Fund. If a miner's last coal mine employment was *after* January 1, 1970, and the claim was filed *after* June 30, 1973, benefits are paid by the coal mine operator judged to be responsible, the so-called "responsible operator," not the Trust Fund. However, the Trust Fund pays benefits if there is no responsible operator among the miner's employers or if the responsible operator is in default. Under the Black Lung Benefits Revenue Act of 1981, liability for certain claims which had been denied prior to March 1, 1978, but which were reviewed and approved under the liberalized eligibility criteria of the Black Lung Benefits Reform Act of 1977, was also transferred to the Trust Fund. When an operator is determined to be responsible for the payment of benefits which in fact have been paid out of the Trust Fund, then the operator is obligated to reimburse the Trust Fund for those amounts plus interest.

The expenses of the Department of Labor and the administrative expenses of the Department of Health and Human Services for the claims program financed through the Trust Fund are paid out of the Trust Fund moneys. The Trust Fund also bears the cost of its own administration as well as the costs of administering the collection of the excise tax on coal.

A claim under part B or C must meet three general conditions in order to be approved for black lung disability benefits: (1) the miner must have (or, if deceased, have had) pneumoconiosis; (2) the miner must be totally disabled by the disease (or must have been totally disabled at the time of death); and (3) the pneumoconiosis must have arisen out of coal mine employment. There are certain statutory presumptions that are used to establish eligibility.

TABLE 1.—NUMBER OF PART C BENEFICIARIES [1]

[Calendar year 1980, September 1985, and December 1988, 1989, and 1990]

Class of beneficiary	1980	1985	1988	1989	1990
Primary beneficiaries:					
Miners	52,922	61,401	54,339	51,588	48,587
Widows	26,739	37,559	41,901	42,923	43,500
Others	1,189	882	1,054	1,110	1,153
Total primary beneficiaries	80,850	99,842	97,294	95,621	93,240
Dependents of primary beneficiaries	58,223	61,010	51,862	48,566	44,251
All beneficiaries	139,073	160,852	149,156	144,187	137,491

[1] Does not include those part B beneficiaries whose medical benefits are paid under part C (nearly 50,000 cases in December 1989). Includes cases (13,000 in December 1989) where payment has been suspended or where a responsible coal mine operator is paying benefits.

Source: Department of Labor.

TABLE 2.—NUMBER OF PART B BENEFICIARIES

[December 1974 and 1980, September 1985, November 1988, September 1989, and August 1990]

Class of beneficiary	1974	1980	1985	1988	1989	1990
Miners	169,097	120,235	79,443	57,421	52,387	47,187
Widows	134,700	146,603	138,902	127,634	124,050	120,151
Others	183,419	132,639	80,476	57,720	52,726	47,823
Total	487,216	399,477	298,821	242,775	229,163	215,161

Source: Social Security Bulletin.

The basic monthly benefit for a miner totally disabled from black lung or a survivor is 37½ percent of the monthly pay of a Federal employee in grade GS-2, step 1. A totally disabled miner or survivor with one dependent receives the basic monthly benefit rate increased by 50 percent. If the miner or survivor has two dependents, the benefit rate is increased by 75 percent, and if there are three or more dependents, the rate is increased by 100 percent. Benefit rates are revised each year to reflect any revision in Federal pay scales. Part B and part C benefit rates are the same except that, pursuant to a provision in the annual appropriations measure, part B benefits are rounded down to the nearest whole dollar. The monthly rates for part C as of January 1991 were:

Miner or one survivor—$387.10.
Miner or survivor with one dependent—$580.60.
Miner or survivor with two dependents—$677.40.
Miner or survivor with three or more dependents—$774.10.

Black lung benefits are not taxed by the Federal Government, although States may do so.

Reductions in black lung benefits or the offset of black lung benefits against other benefits are subject to significantly different rules depending upon whether the benefits are paid under part B or part C. Under part B, black lung benefits are reduced by any payments received under the workers' compensation, unemployment compensation or disability insurance laws of a State if such payments are for death or disability due to pneumoconiosis. If the State payments are made for reasons other than pneumoconiosis, black lung benefits are not reduced. Part C benefits are reduced for State or Federal workers' compensation (but *not* for unemployment compensation or disability insurance) in the same manner.

Under part B, miners or their parents, brothers or sisters (but not their spouse or children) have always been subject to an earnings test which causes their black lung benefits to be reduced as defined in section 203 of the Social Security Act (the same earnings test for Social Security recipients). This excess earnings offset does *not* apply to benefits payable under part C, unless the claim for benefits was filed on or after January 1, 1982.

Under part B, black lung benefits are not considered workers' compensation payments and therefore are not considered in calculating any Social Security disability payments under Title II of the Social Security Act. However under part C, exactly the opposite is the case, and black lung benefits must be taken into account.

Survivor benefits under the black lung program are not reduced as a result of Social Security survivor benefits.

A miner (but not a miner's family or survivors) receiving black lung cash benefits is eligible for medical and rehabilitation benefits including treatment and/or medications prescribed for the miner's black lung disease and directly associated illnesses. Medical costs are paid either by a responsible coal mine operator or by the Trust Fund, whichever is responsible for payment of regular monthly benefits.

FINANCING MECHANISM

A manufacturers' excise tax is imposed on domestically mined coal (other than lignite) which is sold or used by the producer (Internal Revenue Code sections 4121 and 4218). Prior to 1982, the rate of tax was the lesser of (1) 50 cents per ton for coal from underground mines and 25 cents per ton for coal from surface mines, or (2) 2 percent of the price for which the coal was sold. Under 1981 amendments (Public Law 97-119), the rate of tax was doubled to the lesser of (1) $1 per ton for coal from underground mines and 50 cents per ton for coal from surface mines, or (2) 4 percent of the price for which the coal is sold. These higher rates were to revert to the pre-1982 rates on January 1, 1996, or earlier if the Black Lung Disability Trust Fund became solvent (i.e., if the Trust Fund had paid off debts owed the Federal Treasury).

In 1986, the tax rates were increased to their current level: the lesser of (1) $1.10 per ton for coal from underground mines and 55 cents per ton for coal from surface mines, or (2) 4.4 percent of the price for which the coal is sold. As with the earlier tax rates, the current rates (enacted in Public Law 99-272) are to revert to pre-1982 rates on January 1, 1996, or earlier if the Black Lung Disability Trust Fund becomes solvent.

In 1987, Congress, through the Omnibus Budget Reconciliation Act (Public Law 100-203), extended the termination date for the higher coal excise tax rates. The higher rates are to revert to the pre-1982 rates on January 1, 2014, or earlier if the Trust Fund achieves solvency.

Amounts equal to the revenues from this excise tax (plus any revenues from certain penalties on coal mine operators) are appropriated to the Black Lung Disability Trust Fund, for payment of benefits and other Trust Fund expenses.

A responsible operator may fund its liability for black lung benefits through deductible contributions to a qualified tax-exempt trust (code section 501(c)(21)), called coal mine operators' self-insurance trusts. Misuse of a trust due to self-dealing (code section 4951) and expenditures for an improper purpose (code section 4953), trigger certain penalty excise taxes. Amounts collected under these provisions (and from mine operators who fail to fulfill their benefit payment obligations) are appropriated to the Black Lung Disability Trust Fund.

Financial Status of Trust Fund

The Trust Fund has been operating at a deficit since its establishment in 1978. As of fiscal year 1990, it is estimated the Trust Fund has paid over $7.2 billion in cash benefits and medical expenses, along with $540 million in administrative costs. It also has accumulated over $1 billion in interest charges. At the same time, the excise tax on coal has generated only approximately $5.9 billion in revenues, leaving a cumulative deficit of about $3 billion through fiscal year 1990. This deficit has been financed with advances from the general revenues of the U.S. Treasury. These advances must be repaid from future Trust Fund revenues.

Through fiscal year 1985, interest on the cumulative advances to the Trust Fund was also due. However, Public Law 99-272 forgave Trust Fund interest payments for fiscal years 1986 through 1990. This, along with the 10-percent increase in tax rates (discussed above) and reduced benefit spending, substantially reduced the Trust Fund's borrowing (advances from the general fund) beginning in fiscal year 1986.

Table 3 shows the status of the Trust Fund as of the end of fiscal year 1990.

TABLE 3.—STATUS OF BLACK LUNG DISABILITY TRUST FUND

[In thousands of dollars]

Fiscal year	Income			Outgo		
	Coal tonnage tax	Penalties and interest	Advances from general fund	Benefit payments [1]	Administrative expenses	Interest on advances
Actual:						
1978	92,050	1,192	18,925	76,797	35,346	....
1979	221,614	122	400,809	582,038	32,149	7,740
1980	272,262	....	535,837	721,746	34,238	52,497
1981	236,635	....	554,778	644,288	35,585	109,488
1982	490,746	254	283,002	578,244	35,789	160,597
1983	493,685	321	357,773	623,129	34,936	193,273
1984	518,464	450	346,063	594,213	36,551	234,503
1985	581,390	573	335,545	583,422	40,229	274,751
1986	[2] 547,251	1,594	51,271	573,939	44,439	NA
1987	572,295	2,315	67,776	593,201	49,573	NA
1988	594,475	4,079	41,274	584,254	55,105	NA
1989	563,445	8,702	55,853	571,280	55,787	NA
1990	665,348	7,190	155	559,353	51,716	NA
Total	5,884,865	26,792	3,049,061	7,285,904	541,443	1,032,849

[1] Net of benefit collections from responsible mine operators.

[2] Reflects inter-year adjustment. Actual coal tax revenues for 1985 were $561,746,000. For 1986, actual tax revenues totaled $566,845,000.

NA—Not applicable, interest forgiven.

Note: Figures for 1987 have been revised slightly from previous editions.

Source: Fourth Annual Report on the Financial Condition and Results of Operations of the Black Lung Disability Trust Fund (Department of the Treasury, September 30, 1981), Budget of the U.S. Government, Appendixes for fiscal years 1984–1990, and Budget of the U.S. Government for fiscal years 1991 and 1992.

Section 2. Railroad Retirement System

The railroad retirement system is a federally legislated program which provides retirement, disability and survivor annuities to workers whose employment was connected with the railroad industry for at least 10 years. The system, in existence since 1936, was substantially modified by the Railroad Retirement Act of 1974 (RRA) which provided for closer coordination with the Social Security system. Credits are primarily secured by employment in the railroad industry, although any Social Security credits earned during employees' work careers are included in the benefit computation. Benefits are financed through a combination of employee, employer, and Federal Government contributions.

TABLE 1.—MONTHLY RAILROAD RETIREMENT CASH BENEFITS IN CURRENT-PAYMENT STATUS, NOVEMBER 1990

	Number	Percent of total	Average monthly benefit
Total monthly benefits	897,800	100.0	$658
Retired workers	360,500	40.2	888
Disabled workers [1]	34,500	3.8	1,074
Spouses of retired and disabled workers [2]	218,200	24.3	374
Aged widows and widowers	246,300	27.4	547
Disabled widow(er)s	7,200	.8	502
Widowed mothers and fathers	2,100	.2	561
Remarried widow(er)s	5,700	.6	351
Divorced widow(er)s	6,800	.8	383
Children	16,300	1.8	488
Parents	100	([3])	438

[1] Under age 65.

[2] Includes divorced spouses.

[3] Less than 0.05 percent.

Note.—Includes tier I, tier II, vested dual benefits. Excludes 194,200 supplemental annuities averaging $46.

Source: Railroad Retirement Board.

Retirement and survivor benefit payments during fiscal year 1990 totaled $7,195 million. These payments were made to 951,000 beneficiaries. Retired employee and spouse annuitants constituted 650,000 of these beneficiaries and received $5,357 million. Survivor beneficiaries received a total of $1,838 million, consisting of $1,830 million in monthly benefits and over $8 million in lump-sum payments. Information on the number of beneficiaries and average benefit amounts for November 1990 is shown in table 1.

JURISDICTION

In the House of Representatives, the jurisdiction over the railroad retirement system is divided between two standing committees. Under the rules of the House, the Energy and Commerce Committee has jurisdiction over "railroads, including railroad labor, railroad retirement and unemployment, except revenue measures related thereto." That committee, therefore, has jurisdiction over the Railroad Retirement Act which contains the substantive legislation relating to railroad retirement legislation. The Committee on Ways and Means has jurisdiction over all revenue measures, including the Railroad Retirement Tax Act (Chapter 22 of the Internal Revenue Code of 1986). Within the Committee on Ways and Means jurisdiction over employment taxes and trust fund operations relating to the railroad retirement system lies within the Subcommittee on Social Security.

HISTORICAL DEVELOPMENT

In the final quarter of the 19th century, railroad companies were among the largest in America. It was in the rail industry that the first industrial pension was established in 1874. By the mid-1920's more than 80 percent of all rail workers were covered by pension plans.

In the early 1930's these pension plans began to face enormous financial problems. The commercial success of the rail industry peaked in the period between 1900 and 1920, and rail employment decreased significantly in the 1920's.

Rail pension plans were for the most part poorly constructed. There was no regulation of plan terminations, which were frequent. Pension funds were chronically underfinanced, and most could not stand the financial exigencies of the depression.

These problems plus a tradition of Federal regulation of the railroads led to the enactment of the Railroad Retirement Act of 1934.

The original railroad retirement system was structured to provide annuities to retirees based on rail earnings and length of service. Benefits were disbursed for retirees at age 65, although workers with 30 years of service could retire at 60, with a reduction in payments. The original disability provisions were very stringent. Little was provided for dependents, and nothing for spouses.

Throughout its history, the railroad retirement system has been modified many times by Congress. In the late 1940's and 1950's benefits were liberalized, and the railroad retirement system was brought into closer conformity with Social Security. For instance, in 1946, benefits were extended to survivors, based on combined railroad and Social Security covered employment. This extension represented a concern for the social goal of providing income security in old age, or social insurance, rather than simply rewarding career performance.

In the past two decades, the railroad retirement system encountered recurrent financial crises as a result of employment declines in the industry, inflation, and the increase in the number of beneficiaries. Major legislation was enacted in 1974, 1981, 1983, and 1987 to prevent the system from becoming insolvent.

The Railroad Retirement Solvency Act of 1983 (Public Law 98-76) increased payroll taxes on employers and employees, deferred cost-of-living increases, reduced early retirement benefits, subjected benefits to Federal income taxes, and provided other measures designed to improve railroad retirement financing. Without the enactment of this legislation, the Railroad Retirement Board would have been required to substantially reduce benefit payments in 1983. Since enactment, the trust fund has accumulated a reserve of over $9 billion.

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) increased tier 2 tax rates in January 1988 by a total of 2 percent: 1.35 percent on employers and 0.65 percent on employees. In addition, the law extended for 1 year, until October 1, 1989, the time during which revenues from Federal income taxes on tier 2 railroad retirement benefits may be transferred from the general fund of the U.S. Treasury to the Railroad Retirement Account for use in paying benefits.

The continuing decline in rail employment has raised questions concerning the practicality of relying on payroll tax funding in the next century. Consequently, the Committee on Ways and Means included in the 1987 reconciliation bill a provision which established a Commission on Railroad Retirement Reform to conduct a comprehensive study of the issues pertaining to the long-term financing of the railroad retirement system. The Commission consisted of seven members representing railroads, including commuter railroads, labor, and the public, and it made its final report in September 1990. A listing of the Commission's findings and recommendations is reproduced under "Financial Status of the Railroad Retirement Account" at the end of this section.

Railroad retirement amendments were included with railroad unemployment insurance amendments in the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647). This legislation assured repayment of the Railroad Unemployment Insurance Account's debt to the Railroad Retirement Account by extending a temporary unemployment insurance tax until the debt is fully repaid with interest. Public Law 100-647 also eased work restrictions and the crediting of military service in certain cases and provided more equitable treatment of severance pay for railroad retirement purposes.

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) included a number of railroad retirement and Social Security provisions which affect payroll taxes and benefits in 1990 and subsequent years. The law increased the amount of earnings subject to Social Security and railroad retirement payroll taxes by including contributions to 401(k) deferred compensation plans in the measure of average wages, which is used to index the wage base. It also extended for 1 additional year, until October 1, 1990, the time during which revenues from Federal income taxes on tier 2 railroad retirement benefits may be transferred to the Railroad Retirement Account for use in paying benefits. The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) further extended the date of this transfer until October 1, 1992, and also permanently exempted supplemental annuities from reductions under Gramm-Rudman.

ANNUITY STRUCTURE

The 1974 Railroad Retirement Act established three benefit components. The ongoing benefit system was divided into two "tiers," one of which approximates Social Security (tier 1), and the other, an industry staff retirement benefit (tier 2). The third component, a vested dual benefit, preserved certain benefits for employees who had qualified for both railroad retirement and Social Security benefits prior to the 1974 Act.

Tier 1

These benefits are based on the Social Security formula, using both the employee's combined railroad earnings and non-railroad Social Security covered earnings up to the Social Security maximum wage base. The tier 1 benefit is roughly equal to what the Social Security benefit would have been had the worker's railroad employment been covered by the Social Security program. Because the railroad retirement tier 1 benefit is based on both Social Security and railroad employment, any Social Security benefit to which the railroad retirement system beneficiary is also entitled is subtracted from the tier 1 benefit amount. Tier 1 benefits are adjusted for the cost-of-living by the same percentage as Social Security benefits.

Tier 2

Tier 2 benefits are based on the employee's service in the railroad industry alone and are payable in addition to the tier 1 benefit amount. For current retirees, the tier 2 benefit is equal to seven-tenths of 1 percent of the employee's average monthly earnings in the 60 months of highest earnings, times the total number of years of railroad service, less 25 percent of any employee vested dual benefit also payable. Tier 2 benefits are automatically adjusted annually on January 1 at a rate equal to 32.5 percent of the Social Security automatic cost-of-living adjustment.

Dual benefit payments

One of the chief purposes of the Railroad Retirement Act of 1974 was to coordinate railroad retirement and Social Security benefit payments to eliminate certain dual benefits considered to be a "windfall" for persons receiving benefits under both systems.

This "windfall" was a result of the fact that the total benefit these retirees received from both systems was higher than the benefit they would have received if their benefit was based on their total career earnings but paid only under railroad retirement. The total benefit was higher in these cases since the Social Security benefit formula favors workers who have low average earnings throughout their careers. Low career average earnings result from a career of low wages or from a relatively short career in Social Security covered employment. Workers who spend a period of time in employment not covered by Social Security, such as railroad employment, receive the benefit of this "tilt" in the benefit formula, even though they may very well not have had low career earnings.

As a result of the 1974 Act, "windfall" benefits were eliminated for any railroad employees not qualified for such benefits as of January 1, 1975. They were generally preserved for those individuals who were vested under both the railroad retirement and Social Security systems before 1975. These vested dual benefits are financed out of the general revenue fund through an annual appropriation rather than from the Social Security or railroad retirement trust funds, and are subject to reduction during any year in which the appropriation is less than required for full benefit payments. The fiscal year 1990 appropriation was $340,000,000, including income tax transfers. Although appropriations through fiscal year 1990 have been transferred in monthly installments, the fiscal year 1991 appropriation was transferred in toto in November 1990. The total funding for fiscal year 1991 is expected to be about $337 million, including interest on the appropriation and income tax transfers. Currently paid to about one-fourth of the Railroad Retirement Board's beneficiaries, the average vested dual benefit is $118 per month.

Supplemental annuities

These are provided under the 1974 Act equal to $23 for 25 years of service plus $4 for each additional year up to a maximum of $43 per month. However, as a result of the 1981 Omnibus Budget Reconciliation Act, employees hired after October 1, 1981 are not eligible for supplemental annuities when they retire.

Lump-sum death benefits

Lump-sum death benefits are paid when there is no person eligible for a monthly survivor benefit in the month in which the worker died. Generally, 10 years of railroad service and a current connection with the railroad industry are required. For employees with 10 or more years of railroad service before 1975, the amount is based on the 1937 Act. For all other railroad workers, the amount is equivalent to that which would be paid under the Social Security Act (unless survivor benefits are paid).

A residual lump-sum payment is, in effect, a refund of the employee's pre-1975 railroad retirement taxes plus an allowance in lieu of interest, less benefits already paid. This payment is not made as long as monthly benefits are payable either at the time of the employee's death or in the future. However, a widow(er) or parent under age 60 can waive rights to future monthly benefits in order to receive a residual payment.

TREATMENT OF RAILROAD RETIREMENT ANNUITIES UNDER GRAMM-RUDMAN

Tier 1 railroad retirement benefits are exempt from sequestration under the Balanced Budget and Emergency Deficit Control Act (Gramm-Rudman).

The tier 2 COLA was not paid and vested dual benefits were later sequestered during fiscal year 1986 under Gramm-Rudman. Congress amended Gramm-Rudman to fully exempt tier 2 benefits and vested dual benefits from any future sequestration. However, the fiscal year 1988 Labor-Health and Human Services-Education appropriations bill, which reduced domestic discretionary spending by 4.26 percent, lowered the funds available for payment of vested dual benefits. Vested dual benefits were reduced by an average of $6 a month for 6 months. Full payment was resumed in fiscal year 1989.

Supplemental annuities were subject to sequestration until exempted by the 1990 Omnibus Budget Reconciliation Act.[1] They had been temporarily reduced by 8.5 percent during fiscal year 1988. Sequestered amounts were later repaid following enactment of the 1987 reconciliation bill. The fiscal year 1990 sequester which was imposed automatically on October 16, 1989 would have reduced supplemental annuities by an average of $1.25 per month. However, the 1989 reconciliation bill modified the sequester, and the reduction in monthly benefit payments for fiscal year 1990 was revised to average $0.33 per month.

TABLE 2.—TOTAL BENEFIT PAYMENTS AND NUMBER OF BENEFICIARIES, BY FISCAL YEAR

Fiscal year	Benefit payments (in millions)			Beneficiaries (in thousands)		
	Total	Retirement [1]	Survivor [1]	Total	Retirement	Survivor
1950	$301.6	$248.2	$53.4	458	272	189
1955	549.7	424.5	125.2	700	452	252
1960	925.7	711.5	214.2	873	584	299
1965	1,117.7	834.0	283.7	980	650	340
1970	1,593.5	1,177.0	416.5	1,051	702	366
1975	3,060.3	2,222.4	837.9	1,094	733	380
1980	4,730.6	3,389.8	1,340.8	1,084	731	367
1981	5,286.6	3,779.9	1,506.7	1,074	726	363
1982	5,725.5	4,097.9	1,627.6	1,067	722	359
1983	6,041.1	4,354.2	1,686.9	1,056	715	357
1984	6,099.8	4,417.8	1,682.0	1,040	705	351
1985	6,250.9	4,539.3	1,711.6	1,023	694	343
1986	6,329.5	4,608.1	1,721.4	1,007	684	339
1987 [2]	6,520.3	4,773.6	1,746.7	994	675	333
1988	6,675.9	4,915.0	1,760.9	981	666	328
1989	6,938.5	5,140.9	1,797.6	967	659	322
1990	7,194.6	5,357.0	1,837.6	951	650	315

[1] Retirement benefits include tier 1 and tier 2 employee and spouse benefits, employee and spouse vested dual benefits, and employee supplemental annuity payments. Survivor benefits include tier 1 and tier 2 benefits, vested dual benefits and lump-sum payments.

[2] Benefits paid for fiscal years beginning 1987 are not strictly comparable to those in prior years due to a change in accounting systems.

Note: Number of beneficiaries represents all individuals paid benefits in year. In total number for each year, beneficiaries are counted only once, even though they may have received more than one type of benefit. In fiscal year 1990, about 14,000 individuals received both retirement and survivor benefits. Figures are partly estimated.

---

[1] Sequestration of supplemental annuities had been disputed by the General Accounting Office, which argued that Congress intended to exempt all rail pension benefits—both tier 2 and supplemental annuities—from sequestration when it enacted the 1986 budget reconciliation bill. However, the Office of Management and Budget makes the final decision on whether the Gramm-Rudman Act applies to particular programs, and OMB had ruled that railroad retirement supplemental annuities were subject to sequestration.

PROGRAM DATA

Table 2 provides data concerning all railroad retirement benefits paid in selected fiscal years 1950–1990. Table 3 presents data on new awards for November 1990.

TABLE 3.—NUMBER AND AVERAGE AMOUNT OF NEW AWARDS BY BENEFICIARY TYPE, NOVEMBER 1990

	Number	Average amount
Employee annuities:		
Retired	951	$1,080
Disability (under age 65)	277	1,223
Supplemental	707	41
Spouse annuities	1,188	444
Divorced spouse annuities	32	218
Survivor benefits:		
Aged widows and widowers	1,167	632
Disabled widows and widowers	19	538
Widowed mothers and fathers	25	610
Divorced and remarried widows	92	402
Children	71	612
Parents	1	445
Insurance lump sums	333	836
Residual payments	18	4,156
Total	4,881	....

Source: Railroad Retirement Board.

FINANCING THE RAILROAD RETIREMENT SYSTEM

Railroad retirement and survivor benefits are financed by six sources of income. These are (1) payroll taxes on railroad earnings paid by covered employees and employers up to a certain maximum wage base; (2) income from the Social Security financial interchange; (3) proceeds derived from the taxation of railroad retirement benefits; (4) appropriations from general revenues; (5) interest on investments; and (6) a cents-per-hour tax levied on carriers only.

Payroll Taxes

The primary source of income to the railroad retirement account is payroll taxes levied on covered employers and their employees. Currently, both employers and employees pay a "tier 1" tax which is equivalent to the combined Social Security (Old-Age, Survivors and Disability Insurance) and Hospital Insurance (part A of Medicare) tax rate. In addition, a "tier 2" tax is paid by both rail employers and employees. The 1991 annual tier 1 and tier 2 wage bases are $53,400 and $39,600, respectively. The wage base for Hospital Insurance is $125,000.

The scheduled tax rates for both tier 1 and tier 2 are shown in table 4.

TABLE 4.—SCHEDULED TAX RATES FOR TIER 1 AND TIER 2, SELECTED YEARS

	Tier 1		Wage base	Tier 2		Wage base	Combined [1]	
	Employer	Employee		Employer	Employee		Employer	Employee
1975	5.85	5.85	$14,100	9.5	0	$14,100	15.35	5.85
1980	6.13	6.13	25,900	9.5	0	20,400	15.63	6.13
1984	7.00	[2] 7.00	37,800	12.75	2.75	....	19.75	9.75
1985	7.05	7.05	39,600	13.75	3.50	....	20.80	10.55
1986	7.15	7.15	42,000	14.75	4.25	....	21.90	11.40
1987	7.15	7.15	43,800	14.75	4.25	32,700	21.90	11.40
1988	7.51	7.51	45,000	16.10	4.90	33,600	23.61	12.41
1989	7.51	7.51	48,000	16.10	4.90	35,700	23.61	12.41
1990	7.65	7.65	51,300	16.10	4.90	38,100	23.75	12.55
1991	7.65	7.65	[4] 53,400	16.10	4.90	39,600	23.75	12.55
1992 [3]	7.65	7.65	55,500	16.10	4.90	41,400	23.75	12.55
1993 [3]	7.65	7.65	57,900	16.10	4.90	43,200	23.75	12.55
1994 [3]	7.65	7.65	61,800	16.10	4.90	46,200	23.75	12.55
1995 [3]	7.65	7.65	65,400	16.10	4.90	48,900	23.75	12.55
1996 [3]	7.65	7.65	69,000	16.10	4.90	51,600	23.75	12.55

[1] These rates apply only up to the tier 2 maximum wage base.

[2] A credit of 0.3 percent of wages was allowed against the 1984 employee tax rate. Appropriations to the Social Security Equivalent Benefit Account were based on the 7.00 percent rate.

[3] 1992–96 tier 1 and tier 2 wage bases are projected.

[4] The wage base for the 1.45 percent hospital insurance tax, included in the 7.65 percent tier 1 rate, is $125,000 in 1991.

The tier 1 wage base is equal to the Social Security wage base and automatically increases with wage growth in the economy.

The tier 2 wage base is equal to what the Social Security tax base would have been without regard to the ad hoc increases in the taxable wage base which were provided by the Social Security Amendments of 1977 (Public Law 95-215).

Financial Interchange

The railroad retirement system and the Social Security programs have been coordinated financially since 1951. The purpose of the financial interchange is to place the Social Security trust funds in the same position they would have been in if railroad employment had been covered under Social Security since its inception.

Generally, under the interchange, for a given fiscal year there is computed the revenue that would have been collected by the Social Security trust funds if railroad employment had been covered directly by Social Security. This amount is netted against the amount of benefits Social Security would have paid to railroad beneficiaries based on railroad and nonrailroad earnings during that period. Where Social Security benefits that would have been paid exceed income to the trust funds that would have been due, the excess, plus an allowance for interest and administrative expenses, is transferred from the Social Security trust funds to the

Railroad Retirement Board's Social Security Equivalent Benefit Account. If income exceeds benefits, the transfer would be from the RRB's Social Security Equivalent Benefit Account to the Social Security trust funds. Before 1985, transfers were to or from the Railroad Retirement Account.

TABLE 5.—AMOUNTS TRANSFERRED TO OR FROM (—) THE SOCIAL SECURITY EQUIVALENT BENEFIT ACCOUNT [1] AND THE VARIOUS SOCIAL SECURITY TRUST FUNDS IN SELECTED FISCAL YEARS 1954 THROUGH 1990

[In millions of dollars]

	OASI	DI	HI	Total
Fiscal year:				
Through June 30, 1954	−21.1			−21.1
1955	−7.4			−7.4
1960	318.4	−4.9		313.5
1965	435.6	23.6		459.3
1970	578.8	10.4	−63.5	525.7
1975	981.8	28.5	−132.5	877.8
1980	1,442.0	−12.1	−244.3	1,185.6
1981	1,584.9	29.4	−276.5	1,337.9
1982	1,793.3	26.4	−351.4	1,468.2
1983	2,250.8	27.8	−357.7	1,920.9
1984	2,404.0	21.6	−350.6	2,075.0
1985	2,310.2	42.7	−371.4	1,981.5
1986	2,585.1	67.7	−364.4	2,288.4
1987	2,557.3	56.9	−368.0	2,246.2
1988	2,790.0	61.3	−363.8	2,487.5
1989	2,845.3	88.2	−378.8	2,554.7
1990	2,969.3	79.9	−367.4	2,681.8
Total	40,101.7	842.8	−5,084.8	35,859.8

[1] Before 1985, transfers were to or from the Railroad Retirement Account.

Note: Detail may not add to totals because of rounding.

Source: Railroad Retirement Board.

The determination of the amount to be transferred through the financial interchange for a given fiscal year is made no later than June of the year following the close of the preceding fiscal year. Table 5 shows the actual operation of the financial interchange for selected years as it relates to each of the three major Social Security trust funds.

In order to make available to the RRB's Social Security Equivalent Benefit Account funds from the forthcoming financial interchange on a more current basis, the Railroad Retirement Solvency Act of 1983 provided for transfers from general Treasury funds to the RRB's Social Security Equivalent Benefit Account for each month an amount equal to the Social Security level benefits paid from the account during the month less the Social Security level taxes received by the account in that month. The amount so transferred for a particular month is repaid when the Social Security system makes reimbursement for that month under the financial interchange program.

Taxation of benefits

Prior to 1984, railroad retirement benefits, with the exception of supplemental annuities, were not subject to Federal income taxation. However, as a result of the Railroad Retirement Solvency Act (Public Law 98-76) and the Social Security Act Amendments of 1983 (Public Law 98-21), tier 1, tier 2, and vested dual benefits received after December 31, 1983, are subject to taxation. The taxation provisions were subsequently amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. Under current law, the Social Security equivalent portions of tier 1 benefits are taxed in a manner identical to Social Security benefits. The proceeds derived from the taxation of those tier 1 benefits which are equivalent to Social Security benefits are deposited in the Social Security Equivalent Benefit Account and credited to the Social Security trust funds through adjustments in the financial interchange. Tier 1 benefits in excess of Social Security equivalent levels (early retirement benefits payable at ages 60-61 and occupational disability annuities) and tier 2 benefits are taxed in a manner identical to private and public service pensions and the proceeds are deposited in the Railroad Retirement Account through fiscal year 1992. Vested dual benefits are taxed like private and public service pensions with the proceeds derived deposited in the Dual Benefits Payments Account.

General revenue appropriations

Vested dual benefits are funded solely through general revenue appropriations. The Congress authorized such funding in the 1974 act through the year 2000. The total appropriated for the first 15 fiscal years for which these benefits were payable, 1976-1990, was some $5,169 million.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) established a Dual Benefits Payments Account. Each year an amount which is appropriated for the payment of vested dual benefits is placed into this account. If the amount which is appropriated is insufficient to pay the full vested dual benefits to all eligible beneficiaries for a full year, the Railroad Retirement Board is authorized to prorate payments from the dual benefits account so that the amounts paid do not exceed the amounts appropriated.

In addition to amounts transferred to the Dual Benefits Payments Account through the regular appropriations process, the Railroad Retirement Solvency Act of 1983 provided for the appropriation of approximately $1.7 billion to the Railroad Retirement Account in three installments paid on January 1, 1984, 1985, and 1986. These three appropriations were to reimburse the Railroad Retirement Account for prior shortfalls in the annual appropriations. The actual amounts received, including interest, totaled $2,128 million. This amount is not included in the figure given above for total appropriations, 1976-90.

Interest from investments

Funds not needed immediately for benefit payments are invested in interest-bearing securities. During fiscal year 1990, the Railroad Retirement Account and Social Security Equivalent Benefit Account received $796 million in interest income from invested assets. This represents an annualized yield of 9.32 percent.

Cents-per-hour tax

A cents-per-hour tax is used to fund the supplemental annuity benefit. This tax is levied solely on employers. The rate, 26¢ per workhour in January 1991, is determined quarterly by the Railroad Retirement Board.

FINANCIAL STATUS OF THE RAILROAD RETIREMENT ACCOUNT

One of the most important factors affecting the financial status of the railroad retirement system is the level of employment in the industry. The recent history of industry employment is shown in chart 1 and table 6 below.

TABLE 6.—HISTORIC LEVELS OF INDUSTRY EMPLOYMENT, 1940–90

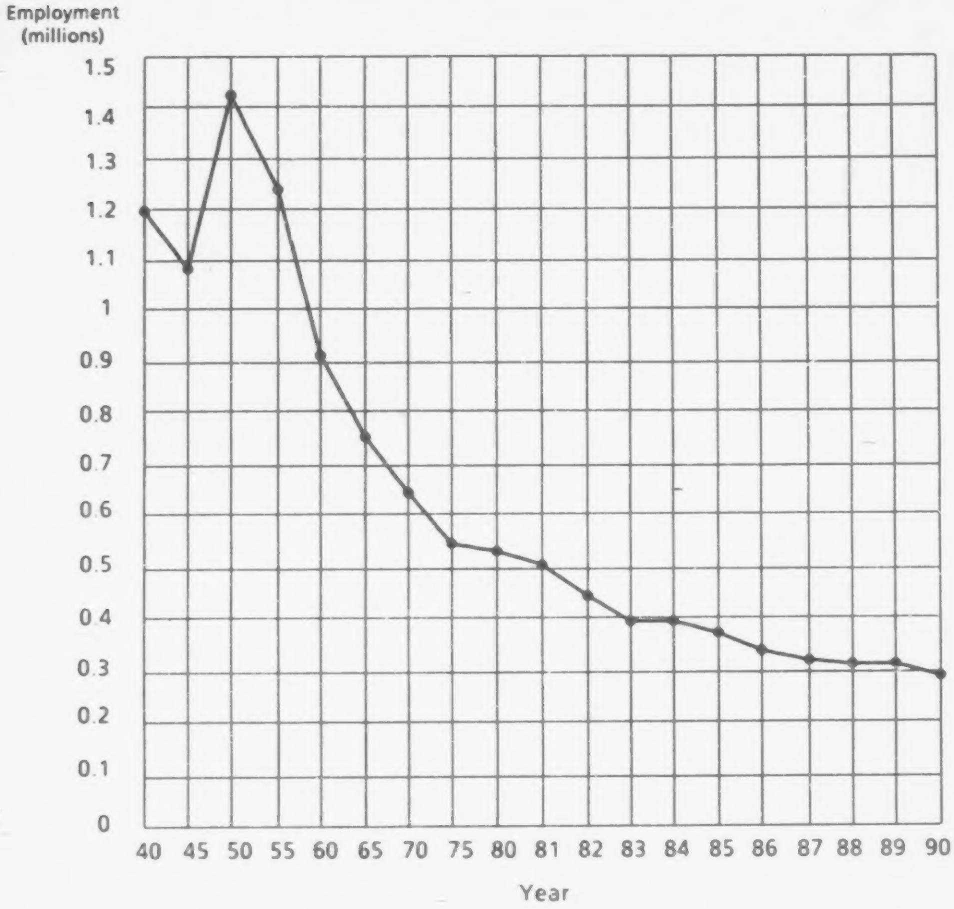
[In thousands]

1940	1,195
1945	1,085
1950	1,421
1955	1,239
1960	909
1965	753
1970	640
1975	548
1976	540
1977	546
1978	542
1979	554
1980	532
1981	503
1982	440
1983	395
1984	395
1985	372
1986	342
1987	320
1988	312
1989 [1]	308
1990	296

[1] Revised.

Source: Railroad Retirement Board.

CHART 1. HISTORIC LEVELS OF INDUSTRY EMPLOYMENT, 1940–90



While the trust funds currently have a reserve of over $9 billion, the continuing decline in railroad employment has raised questions concerning the financing of the railroad retirement system after the year 2000. Section 502 of the Railroad Retirement Solvency Act of 1983 requires a report each year on the railroad retirement system's actuarial status, and financing recommendations when appropriate. Because of the decline in employment, the Railroad Retirement Board's Chief Actuary recommended in his 1987 report that a commission be established to study the advisability of instituting a tax on operating revenues to fund a portion of the cost of railroad retirement benefits, and that such a study should solicit the views of railroad labor, railroad management and other interested parties. He also recommended that tier 2 taxes be increased until any tax adjustments recommended by the commission become effective.

Under the 1987 budget law, the Commission's study was to take into account—

(1) the possibility of restructuring the financing of railroad retirement benefits through increases in the tier 2 tax rate, in-

creases in the tier 2 tax wage base, the imposition of a tax on operating revenues, revisions in the investment policy of the railroad retirement pension fund, and establishing a privately funded and administered railroad industry pension plan;

(2) the economic outlook for the railroad industry, and the nature of the relationships between the railroad retirement system, levels of railroad employment and compensation, and the performance of the rail sector;

(3) the ability of the system under current law to pay benefits to current and future retirees and other beneficiaries;

(4) the financial relationship of the system to the railroad unemployment insurance system, the Social Security system, and the General Fund; and

(5) any other matters which the Commission considers would be necessary, appropriate, or useful to the Congress in developing legislation to reform the system.

The 1987 budget law also increased tier 2 payroll tax rates in January 1988 by a total of 2 percent, and allowed revenues from Federal income taxes on tier 2 railroad retirement benefits to be returned to the railroad retirement system until October 1, 1989; later legislation extended the date to October 1, 1990, and then to October 1, 1992.

The Railroad Retirement Board's 1989 actuarial report was generally favorable. It indicated that, barring a sudden substantial drop in railroad employment, the system will not experience cashflow problems during the next 20 years, but that the long-term stability of the system is still questionable in view of the continuing decline in rail employment and the system's reliance on payroll taxes for funding. The 1990 report was slightly more favorable, but did not change any of the basic conclusions of the 1989 report.

The following list of major findings and recommendations is reprinted from the press release which accompanied the Commission on Railroad Retirement Reform's September 1990 final report.

List of major findings and recommendations

1. The Railroad Retirement system is financially sound in the intermediate-term.
2. It is quite probable that the Railroad Retirement system is financially sound over the long-range future (the next 75 years).
3. Tier 2 of the railroad retirement system has elements of both a social insurance program and a private-pension tier for railroad employees. The system is actuarially sound as the term is applied to a social insurance program.
4. Based on its review, the Commission concluded that, on balance, the future of the national economy appears to be favorable over the next decade for the freight railroad sector.
5. Employment projection D used in the 17th Actuarial Valuation [of the Railroad Retirement Board] is the most reasonable and predictive of the five projections. In fact, this projection appears to be on the low side.
6. The Railroad Retirement Tax Act should be amended to substitute a partial-pegged-payroll tax for the current employment-based employer tax. If this alternative tax basis is adopted, the

statute should clearly indicate that these tax payments are to be recorded as period expenses when paid.

7. If the partial-pegged-payroll tax is not adopted, and if contracting-out increases as a problem, causing reduced employment, serious consideration should be given to imposing an excise tax on contracting-out, either as a tax on all outlays or limited to "traditional" railroad services.

8. The current temporary transfers of income-tax revenue on tier 2 and unrecompensed tier 1 benefits should be continued on a permanent basis.

9. The Commission recommends the development of alternative retirement systems for newly hired railroad employees only, and proposes transition rules to encourage the development of satisfactory individual company and/or multiemployer pension plans for such new employees.

10. The early-retirement provisions of the Railroad Retirement Act should be phased out to provide eventual retirement-age requirements which are the same as those under Social Security.

11. The "notch" in the early-normal-retirement-age reduction factor should be changed in an actuarially correct manner.

12. The occupational-disability annuity provisions of the Railroad Retirement Act should be amended to provide that, effective for disabilities occurring on or after January 1, 1994, the duration for receipt of such benefits is to be limited to 24 months.

13. In conjunction with the phase-out of the early-retirement provisions and modification of the occupational-disability annuity eligibility, the Railroad Retirement Act should be amended to conform the provisions for tier 1 benefits to the benefits provided under the Social Security Act for those individuals who become entitled or eligible on or after the effective date.

14. The Railroad Retirement Act should be changed so as to restore the previous cross-reference to the Federal Insurance Contributions Act for determining tier 1 tax rates. [The cross-reference was restored by the 1990 Omnibus Budget Reconciliation Act.]

15. A further increase in the current tier 2 tax rates is not needed if the present benefit structure remains unchanged. The current procedure of regular financial reporting by the Railroad Retirement Board, with recommendations for adjustments to the tax rates if necessary, is an efficient and adequate mechanism for any future corrective action.

16. Increasing the tier 2 taxable compensation base is not recommended.

17. The Railroad Retirement Tax Act should be amended to allow individual employers to assume the employee tier 2 tax, and such payments made by the employer should not be included as compensation for RRTA or income tax purposes.

18. The financial relationship of the Railroad Retirement Account and the General Fund through the Dual Benefits Payments Account is appropriate and should be continued.

19. The proposal in the fiscal year 1991 budget of the United States to modify the current method of calculating the appropriation for the dual-benefits payments should be rejected because it would be an abrogation of past agreements and because it lacks a

sound rationale. [This proposal was also contained in the fiscal year 1992 budget submitted by President Bush.]

20. No change in the financial interchange relationship between the Railroad Retirement Account and the Social Security system is recommended.

21. The Railroad Retirement Account and the Social Security Equivalent Benefit Account should be combined (as the Railroad Retirement Account), and should no longer be maintained as separate accounting entities.

22. No change in the relationship between the Railroad Unemployment Insurance Account and the Railroad Retirement Account is recommended.

23. Concerning the investment management of the Railroad Retirement Account: (1) The statutory formula for determining the monthly rate of interest to be earned by the Account on par value special issues of the U.S. Treasury should be changed from one based on notes of at least 3 years to maturity, to all "marketable interest-bearing obligations" of at least 4 years to maturity; (2) The current statutory investment authority should be continued; and (3) If the partial-pegged-payroll tax alternative is not adopted, and the balance in the Railroad Retirement Account increases to a more than adequate level (e.g., 3 or 4 years of anticipated outgo), Congress should consider granting the Board more flexible investment authority, so as to include private-sector investments.

24. Tier 1 benefits should be extended to the divorced-spouse categories of beneficiaries which are now excluded from receiving such benefits.

25. The Railroad Retirement Act should be amended to require the simultaneous filing of employee and spouse annuities to which an individual is entitled.

26. The Railroad Retirement Act should be amended to provide that all future benefit changes in the Social Security Act shall apply to tier 1 benefit provisions of the Railroad Retirement Act.

27. The Railroad Retirement Act should be amended to provide that coverage should apply to all interurban passenger railroads which recieve any direct or indirect Federal funding for their operations or construction, regardless of whether or not they operate between states.

28. No separate special tax-treatment should be provided for passenger railroads.

Section 3. Railroad Unemployment Compensation System

The railroad unemployment compensation (RRUC) system has been in existence since 1938. Railroad workers were initially covered by the unemployment provisions of the Social Security Act of 1935. The Railroad Unemployment Insurance Act (Public Law 75-722) was passed in 1938 to provide a uniform unemployment insurance system for all railroad workers, regardless of the State in which they worked or lived. This was done largely because of administrative problems at that time in handling claims for railroad workers who earned wages in a number of different States and as a result of the railroad unions' desire that individuals throughout the industry be treated the same for purposes of unemployment compensation.

The Technical and Miscellaneous Revenue Act of 1988 (Public Law 100-647) increased the railroad unemployment and sickness daily benefit rate, indexed future benefit rates, qualifying earnings requirements and the contribution base to national wage levels, established a waiting period for benefits, and included other measures to improve the railroad unemployment insurance system's financing.

BENEFITS AND ELIGIBILITY REQUIREMENTS

A new benefit year for unemployment and sickness benefits begins every July 1. To qualify in the benefit year beginning July 1, 1991, a worker must have base year railroad earnings of at least $1,862.50 in the preceding calendar year, not counting earnings over $745 per month. Under the indexing provisions of the law reflecting growth in average national wages, a worker must have base year earnings of $1,912.50 in calendar year 1991, not counting earnings of more than $765 per month, to qualify in the benefit year beginning July 1, 1992. If the base year was the first year of railroad service, the worker also must have worked in 5 months of that year.

No benefits are payable for the first claims for unemployment and sickness in a benefit year. This generally results in a 2-week waiting period. A claimant is normally paid for days of unemployment or sickness over 4 in 14-day registration periods.

The maximum daily benefit currently payable is $31; and, for biweekly claims, maximum benefits can total $310. As a result of sequestration under the Balanced Budget and Emergency Deficit Control Act, unemployment and sickness benefits have been reduced periodically since 1986. In fiscal year 1990 maximum biweekly benefits were initially reduced from $310 to $293.57. The Omnibus Budget Reconciliation Act of fiscal year 1990 revised the biweekly rate to $304.73. The fiscal year 1991 budget reconciliation legislation precluded reductions during the 1991 fiscal year.

The program offers "normal" benefits and two categories of "extended" benefits. The duration of benefits varies by worker. Qualified workers can receive normal benefits for up to 130 days or 26 weeks, but the total may not exceed their creditable wages in the base year. Two groups of workers may get extended benefits:

(1) Workers with at least 15 years of railroad service may get up to 130 additional days, or up to an additional 26 weeks of benefits beyond the normal 26 weeks; and

(2) Workers with at least 10 but fewer than 15 years of railroad service may receive up to 65 additional days or 13 additional weeks.

TABLE 1.—PERMANENT BENEFITS UNDER THE RAILROAD UNEMPLOYMENT COMPENSATION PROGRAM AS OF DECEMBER 31, 1990

Qualifying wages:	
Base year 1989	$1,775.00
Base year 1990	$1,862.50
Base year 1991	$1,912.50
Daily benefit rate:	
Basic rate	60 percent of daily rate of pay.
Maximum:	
Benefit year 1990–91	$31.00
Benefit year 1991–92	$31.00
Minimum guarantee	$12.70
Maximum normal benefits:	
For 14-day period:	
Benefit year 1990–91	$310
Benefit year 1991–92	$310
For benefit year:	
Duration	130 compensable days.
Amount:[1]	
Benefit year 1990–91	$4,030
Benefit year 1991–92	$4,030
Maximum extended benefits:	
10–14 years' service:	
Duration	65 compensable days.
Amount:	
Benefit year 1990–91	$2,015
Benefit year 1991–92	$2,015
15 or more years' service:	
Duration	130 compensable days.
Amount:	
Benefit year 1990–91	$4,030
Benefit year 1991–92	$4,030

[1] Not to exceed the employee's taxable earnings in the base year counting earnings up to $917 a month for benefit year 1990–91 (base year 1989) and $962 a month for benefit year 1991–92 (base year 1990).

Note.—Some net sickness benefits are somewhat less than the above amounts since they are subject to tier I railroad retirement taxes.

Source: U.S. Railroad Retirement Board Handbook on Railroad Retirement and Unemployment Insurance Systems, January 1991.

The average duration of benefits fluctuates closely with the unemployment rate. In the 1940 through 1989 period, it ranged from 7.4 to 19.1 weeks and averaged 12 weeks.

In 1946, a program of cash sickness benefits was established for railroad workers as part of the unemployment compensation system. Sickness benefits are financed out of the same employer paid payroll taxes used to finance unemployment compensation benefits. A qualified railroad worker may receive sickness benefits if he files a "statement of sickness" signed by a doctor and mailed within 7 days of the first day for which a day of sickness is claimed.

A rail worker who is unemployed due to a strike not in violation of the Railway Labor Act of 1926 can receive unemployment compensation benefits after a 14 day waiting period. Unemployment benefits cannot be paid to individuals participating in a strike that is in violation of the Railway Labor Act, and is therefore "illegal." Individuals who are unemployed due to an "illegal" strike, but who are not actually participating in the strike, are eligible for unemployment compensation benefits but are subject to the 14 day waiting period.

Total expenditures for unemployment and sickness payments were $90 million in benefit year 1989–90, which was 0.8 percent of total wages paid by the industry during the same period. This compares to a peak of 5.1 percent in 1959. It is also much lower than in benefit year 1983, a recession year, when the figure was 3.9 percent. Since the beginning of sickness benefits, unemployment benefits have composed about two-thirds of total payments. In 1990, unemployment benefits accounted for 64 percent of the total.

Benefit payments vary directly with the insured unemployment rate, covered employment, average weekly benefit amount, and average duration of benefits. The insured unemployment rate is the percentage of workers qualified under the RRUC program who drew benefits in a particular benefit year. The railroad insured unemployment rate has been high and volatile since the beginning of the RRUC program, averaging 14 percent. Since 1946 it has ranged from a relatively low 7 percent to 30 percent in benefit year 1982–83.

Changes in covered employment have short-run and long-run effects on the RRUC program. In the short run, when layoffs cause employment to decline, the insured unemployment rate and benefits paid increase. In the long run, when employers have fewer workers to layoff, benefits decline and the program shrinks. Since the peak of 1,680,000 workers in calendar year 1945, railroad employment declined to 296,000 in 1990. Two-thirds of this decline occurred in the 20 years between 1945 and 1965. In the 25 years since then, the remaining one-third of the decline occurred. In other words, the average annual decline through 1965 was 46,000, but after 1965 it was 18,000.

TAXES

The railroad unemployment and sickness benefit programs are financed by payroll taxes on railroad employers. The employees do not pay railroad unemployment taxes. The taxable earnings base in calendar year 1991 is the first $765 of each employee's monthly earnings. The earnings base is indexed each year by a rate which is equal to approximately two-thirds of the annual rate of increase in the maximum base for railroad retirement tier 1 taxes.

Experience-based tax rates are being phased in on a partial basis in 1991 and 1992, and become fully effective in 1993 with a maximum of 12 percent, or 12.5 percent if a maximum surcharge is in effect.

Railroad unemployment taxes are collected by the Railroad Retirement Board. Of each year's tax receipts, an amount equal to 0.65 percent of taxable payroll is set aside for administration. Excess funds allocated but not needed for administration are transferred to the Railroad Unemployment Insurance Account at the end of each fiscal year.

The Railroad Unemployment Insurance and Railroad Unemployment Insurance Administration Accounts are part of the Federal Unemployment Trust Fund. This trust fund has 53 State UC program accounts, 4 Federal accounts, and the 2 railroad accounts.

Since 1959, the railroad unemployment trust fund has been able to borrow funds from the railroad pension fund when employer taxes have not been sufficient to cover the costs of unemployment and sickness benefits. In the past, borrowed funds have been repaid. The RRUC program became depleted for the first time in 1960 after a long decline from peak reserves of nearly 18 percent of total annual wages in 1948. By 1963, it owed the retirement account $314 million, or 5.9 percent of total annual wages paid in the industry that year. The program gradually recovered during the 1960s until it had positive reserves again in 1974. Thereafter, the reserves were depleted again in 1976 through 1978, and 1981 through 1990.

A rapid decline in 1981 and 1982 in railroad employment resulted in substantial borrowing from the pension system which reached a peak level of over $850 million at the end of 1986. But, by the end of 1990, the debt had been reduced to approximately $330 million, about 3 percent of total wages projected to be paid in the industry that year.

Financial measures to assist the Railroad Unemployment Insurance Account were included in the Railroad Retirement Solvency Act enacted August 12, 1983.

The Solvency Act raised the taxable limit on monthly earnings and the base-year qualifying amount. The waiting period for benefits during strikes was increased from 7 to 14 days. A temporary repayment tax on railroad employers began July 1, 1986, to initiate repayment of the loans made by the Railroad Retirement Account.

The 1983 legislation also mandated the establishment of a Railroad Unemployment Compensation Committee to review the unemployment and sickness benefit programs and submit a report to Congress. The Committee reviewed all aspects of the railroad unemployment insurance system, in particular repayment of the system's debt to the Railroad Retirement Account, and the viability of transferring railroad unemployment benefit payments to State programs.

The Consolidated Omnibus Budget Reconciliation Act of April 1986 (Public Law 99-272) amended the temporary unemployment insurance loan repayment tax beginning July 1, 1986, continued authority for borrowing by the Railroad Unemployment Insurance Account from the Railroad Retirement Account, and provided a contingency surtax on rail employers if further borrowing took place.

The 1988 Technical and Miscellaneous Revenue Act railroad unemployment insurance amendments were based on the recommendations of the Railroad Unemployment Compensation Committee. The 1988 amendments improved financing by indexing the tax base to average national wages and experience rating employer contributions. Repayment of the unemployment system's debt to the retirement system was assured by fixing the loan repayment tax at 4 percent of the contribution base, remaining in force at that rate until the debt is fully repaid with interest. Under economic assumptions similar to Social Security actuaries II–B alternative, the debt will be fully repaid by the end of fiscal year 1994.

A contingency surtax (3.5 percent) effective in the event of further borrowing by the Railroad Unemployment Insurance Account, was eliminated in 1991. Instead, a surcharge will be added to employers' unemployment insurance taxes for a calendar year if the balance in the unemployment insurance account on the previous June 30 goes below $100 million. The surcharge rate would be 1.5, 2.5, or 3.5 percent depending on how low the balance had fallen. If a 3.5 percent surcharge goes into effect for a given year, the maximum rate for any employer would be 12.5 percent rather than 12 percent. If the account balance on the preceding June 30 is above $250 million, the excess will be refunded to the employers in the form of a rate reduction for the year through a pooled credit.

The 1988 amendments require the Board to make annual financial reports to Congress beginning July 1989 on the status of the unemployment insurance system. The reports must include any recommendations for financing changes which might be advisable, specifically with regard to rates of employer contributions.

The Board's 1990 financial report stated that experience-based contribution rates would keep the system solvent, even under the most pessimistic assumptions, that the debt to the Railroad Retirement Account will be fully repaid by the end of fiscal year 1994, and that no new loans will be required during the 10-year projection period (fiscal years 1990–99). The Board, therefore, recommended no changes to the system in its 1990 report.

TABLE 2.—RAILROAD UNEMPLOYMENT AND SICKNESS INSURANCE PROGRAM STATISTICS

	Benefit year ending in														
	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991 (est.)	1992 (est.)
Insured railroad unemployment (percent) [1]	11.2	12.6	17.0	21.4	29.8	39.9	26.0	19.5	22.3	20.1	15.6	10.5	9.3	9.5	9.5
Coverage (thousands of qual. employees)	704,662	617,035	598,234	569,264	511,858	458,647	445,189	419,882	393,019	366,415	348,586	336,325	323,000	314,000	306,000
Average daily benefit:															
Unemployment:															
Current dollars	12.61	12.68	24.94	24.97	24.98	24.99	24.98	24.98	24.97	[2] 24.76	[3] 24.75	N/A	[4] 30.16	N/A	N/A
In 1990 dollars [5]	40.30	30.13	40.10	36.46	34.08	32.61	31.27	30.18	29.42	28.37	27.22	N/A	30.16	N/A	N/A
Sickness:															
Current dollars	12.66	12.69	24.97	24.99	24.99	24.99	24.99	24.99	24.98	[2] 24.71	[3] 24.76	N/A	[4] 30.25	N/A	N/A
In 1990 dollars [5]	40.46	30.16	40.15	36.49	34.10	32.61	31.27	30.19	29.44	28.32	27.23	N/A	30.25	N/A	N/A
Number of beneficiaries:															
Unemployment (thousands)	79.2	77.9	101.6	121.9	152.4	182.9	115.6	81.7	87.6	75.2	54.4	35.2	29.9	29.8	29.1
Sickness (thousands)	91.4	67.4	76.8	75.2	59.3	62.9	57.2	51.6	49.5	45.2	41.7	33.7	28.2	29.0	28.3
Benefit exhaustions, normal benefits:															
Unemployment (thousands)	6.2	4.8	11.2	27.9	36.0	67.6	34.4	17.4	16.1	17.0	10.6	6.6	5.6	N/A	N/A
Sickness (thousands)	16.8	7.9	9.5	9.4	9.3	10.0	8.8	8.0	8.8	9.1	8.4	7.6	6.1	N/A	N/A
Amount paid:															
Unemployment (millions)	35.0	37.5	112.7	216.0	247.7	356.6	203.0	125.8	140.4	118.6	85.8	60.8	57.2	65.6	68.5
Sickness (millions)	57.9	29.6	60.0	60.6	54.7	56.7	45.4	43.8	47.4	55.7	24.8	32.1	32.6	45.3	49.3
Total tax collection:															
Benefits account (millions)	122.7	109.4	173.3	148.0	186.7	162.7	170.3	223.1	213.2	192.6	186.9	181.9	192.5	191.2	144.3
Administration (millions)	8.2	7.3	12.9	13.2	12.0	11.5	10.5	15.2	14.2	12.9	12.7	13.9	15.4	17.7	17.7
Outlays:															
Benefits (millions)	93.0	67.1	172.7	276.6	302.4	[4] 413.4	248.4	169.6	187.8	174.3	110.6	92.9	89.8	110.9	117.8
Administration (millions)	6.6	7.3	11.2	13.8	14.1	14.0	13.7	14.8	15.2	14.3	14.2	13.5	14.6	15.3	16.0
Account balance (millions)	−77.1	113.9	62.7	−120.1	−227.4	−581.3	−725.0	−720.2	−499.7	−653.3	155.0	239.5	226.9	314.5	373.6

---

[1] Unemployment beneficaries divided by qualified employees; does not include sickness insurance beneficiaries. [2] Benefit amounts for registration periods beginning on August 1 through September 17, 1986, were reduced 7.4 percent under the Gramm-Rudman-Hollings Act. [3] Benefit amounts for claims processed on or after November 20 were reduced 8.5 percent under the Gramm-Rudman-Hollings Act. Benefit payments were restored to previous levels in late December 1987 and refunds of previously withheld amounts were made in the first week of January. [4] Benefit amounts for registration periods beginning on or after October 1, 1989, were originally reduced by 5.3 percent under the Gramm-Rudman-Hollings Act. On February 10, 1990, the final fiscal year 1990 Gramm-Rudman-Hollings sequestration rate of 1.7 percent was implemented for all days of unemployment and sickness after September 30, 1989. Refund payments were issued on February 13, 1990. Cumulative averages do not reflect these refunds. [5] Calculated using the fiscal year CPI–X1 price index.

Section 4. Vaccine Injury Compensation Trust Fund

LEGISLATIVE HISTORY

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) established in the Treasury the Vaccine Injury Compensation Trust Fund, effective January 1, 1988 (Internal Revenue Code sec. 9510).

FINANCING MECHANISM

The Omnibus Budget Reconciliation Act of 1987 imposed an excise tax on the sales of certain vaccines (sec. 4131). The tax per dose is: $4.56 for diptheria, pertussis, and tetanus (DPT) vaccines; $0.06 for diptheria and tetanus (DT) vaccines; $4.44 for measles, mumps, and rubella (MMR) vaccines; and $0.29 for polio vaccines. The vaccine excise tax will expire after the later of: (1) December 31, 1992; or (2) the date on which the Vaccine Injury Compensation Trust Fund revenues exceed the projected liabilities with respect to compensable injuries from vaccines administered before October 1, 1992.

EXPENDITURE PURPOSES

The Vaccine Injury Compensation Trust Fund provides a source of compensation for individuals who die or are injured as a result of the administration of DPT, DT, MMR, and polio vaccines. The compensation program applies only to injuries from vaccines administered after September 30, 1988, and before October 1, 1992.

TABLE 1.—OPERATIONS OF THE VACCINE INJURY COMPENSATION TRUST FUND

[Dollars in millions]

Fiscal year	Receipts	Outlays	Trust fund balance (end of year)	Number of new, claims
1988	$77.5	0	$77.5	NA
1989	109.6	$.7	186.4	NA
1990	180.1	2.3	364.2	NA
1991 (estimate)	131.1	159.8	335.5	NA
1992 (estimate)	138.5	91.9	382.1	NA

[1] Receipts includes both excise tax receipts and interest income.

NA=not available.

Source: HHS, OMB, and Ways and Means Committee staff.

PART 3

BUDGET TABLES, DESCRIPTION OF FISCAL YEAR 1992 ADMINISTRATION BUDGET PROPOSALS, AND DESCRIPTION OF THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985 AS AMENDED

Section 1. Budget Tables

TABLE 1. CBO AND OMB BASELINE ESTIMATES (ASSUMING COMPLIANCE WITH DISCRETIONARY SPENDING CAPS)

[By fiscal year]

	1991	1992	1993	1994	1995	1996
	In billions of dollars					
Revenues:						
CBO	1,092.8	1,169.2	1,250.7	1,331.5	1,415.4	1,495.4
OMB	1,091.1	1,162.3	1,252.1	1,366.0	1,468.2	1,565.1
Outlays:						
CBO	1,401.6	1,463.4	1,471.8	1,500.7	1,484.2	1,561.2
OMB	1,401.4	1,447.2	1,464.4	1,433.5	1,480.3	1,551.0
Deficit or surplus:						
CBO	−308.8	−294.2	−221.0	−169.2	−68.8	−65.7
OMB	−310.3	−284.9	−212.3	−67.5	−12.1	14.1
	As a percentage of GNP					
Revenues:						
CBO	19.4	19.5	19.5	19.5	19.5	19.4
OMB	19.4	19.4	19.5	19.9	20.0	20.0
Outlays:						
CBO	24.9	24.4	23.0	22.0	20.5	20.3
OMB	25.0	24.2	22.8	20.8	20.2	19.9
Deficit or surplus:						
CBO	−5.5	−4.9	−3.5	−2.5	−.9	−.9
OMB	−5.5	−4.8	−3.3	−1.0	−.2	.2

Note: Totals include Social Security, which is off-budget.

Sources: Congressional Budget Office; Office of Management and Budget.

TABLE 2.—SAVINGS REQUIRED TO COMPLY WITH THE DISCRETIONARY SPENDING CAPS

[By fiscal year, in billions of dollars]

	1991	1992	1993	1994	1995	1996
CBO baseline deficit,[1] without caps	309	307	242	217	134	137
Further reductions:						
Defense discretionary	0	−10	−19	(2)	(2)	(2)
International discretionary	0	(3)	(3)	(2)	(2)	(2)
Domestic discretionary	0	−4	−3	(2)	(2)	(2)
Subtotal	0	−13	−22	−47	−61	−63
Employer's share of employee retirement	0	1	2	3	5	5
Debt service	0	−1	−2	−4	−8	−13
Total	0	−13	−21	−48	−65	−71
CBO baseline deficit, with caps	309	294	221	169	69	66
Memoranda: Deficit Excluding deposit insurance	205	197	174	145	116	108
Deficit excluding Social Security and Postal Service (on-budget deficit)	369	364	301	266	181	194

[1] Includes Social Security which is off-budget

[2] A single cap applies to the three categories of discretionary spending—defense, international, and domestic—in 1994 and 1995. The assumed cap for fiscal year 1996 represents a CBO extrapolation.

Source: Congressional Budget Office.

TABLE 3.—CBO PROJECTIONS OF TRUST FUND SURPLUSES

[By fiscal year, in billions of dollars]

Trust fund	1991	1992	1993	1994	1995	1996
Social Security	60	70	81	96	111	128
Medicare	14	16	18	17	15	12
Military retirement	14	12	12	12	11	11
Civilian retirement [1]	23	25	27	29	31	30
Unemployment	−1	3	6	9	10	10
Highway and Airport	4	4	4	4	4	5
Other [2]	3	2	1	2	2	2
Total trust fund surplus [3]	117	132	151	171	188	203
Federal funds deficit [3]	−425	−427	−372	−340	−257	−269
Total deficit	−309	−294	−221	−169	−69	−66
Memoranda: Trust fund deficit excluding transfers from General Fund	−63	−58	−58	−58	−63	−73
Federal funds deficit excluding transfers to trust funds	−246	−236	−163	−111	−6	7

[1] Civil Service Retirement, Foreign Service Retirement, and several smaller funds.

[2] Primarily Railroad Retirement, employees' health insurance and life insurance, Hazardous Substance Superfund, and various veterans' insurance trust funds.

[3] Assumes that discretionary spending reductions are made in non-trust-fund programs.

Source: Congressional Budget Office.

TABLE 4.—TRUST FUND SURPLUSES, 1981–90

[In billions of dollars]

Account	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Social Security	−5	−8	(1)	(1)	9	17	20	39	52	58
Medicare	3	5	6	6	4	6	9	15	22	15
Military retirement					12	12	14	14	14	12
Civilian retirement [2]	11	12	14	15	18	19	18	19	20	22
Unemployment	−1	−4	−1	4	5	4	7	8	7	6
Highway and airport	−2	−1	1	4	2	1	2	2	4	2
Other [3]	1	2	2	5	5	3	3	1	4	5
Total trust fund surplus	7	6	23	33	54	62	73	98	124	120
Federal funds deficit	−86	−134	−231	−218	−266	−283	−222	−253	−276	−341
Overall deficit	−79	−128	−208	−185	−212	−221	−150	−155	−152	−220

[1] Less than $500 million.
[2] includes Civil Service Retirement, Foreign Service Retirement, and several smaller funds.
[3] Includes primarily Railroad Retirement, Employees' Health Insurance and Life Insurance, and Hazardous Substance Superfund.

Source: Congressional Budget Office.

TABLE 5.—OUTLAYS FOR MAJOR SPENDING CATEGORIES FOR SELECTED YEARS IN NOMINAL DOLLARS, AND AS A PERCENT OF GNP

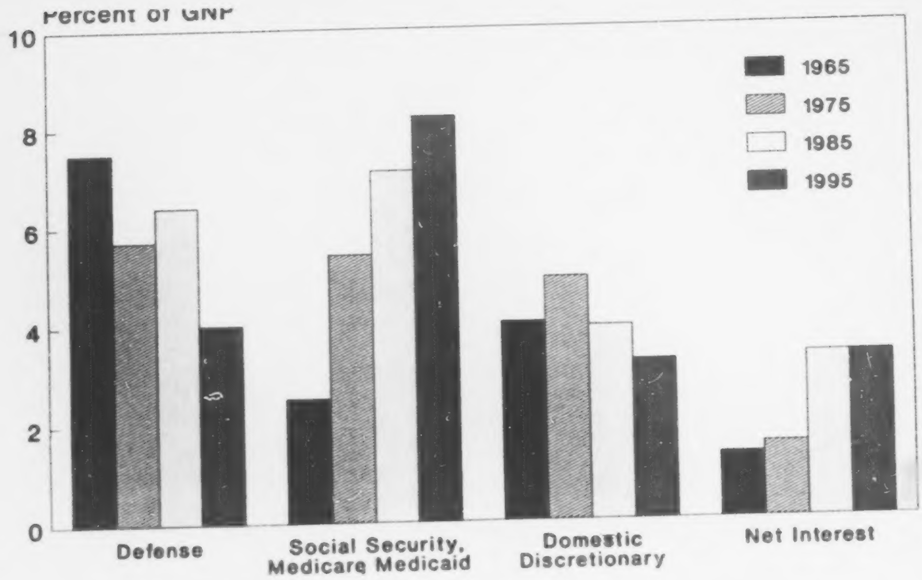
[By fiscal year]

	1965	1970	1975	1980	1985	1990	1995
	In nominal dollars (billions)						
National Defense	50.6	81.7	86.5	134.0	252.7	299.3	[1] 289.0
International discretionary	5.5	4.5	8.4	12.8	17.4	19.1	[1] 21.4
Domestic discretionary	26.8	40.7	74.7	139.6	154.9	186.4	[1] 232.8
Subtotal, discretionary	82.9	126.8	169.5	286.4	425.0	504.9	[1] 543.2
Social Security	17.1	29.4	63.1	117.1	186.5	246.5	335.4
Medicare	.0	6.8	14.1	33.9	69.8	107.4	173.6
Medicaid	0.3	2.7	6.8	14.0	22.7	41.1	84.1
AFDC, SSI, Food Stamps	2.8	4.7	14.1	22.2	30.4	39.7	60.8
Deposit insurance	−.4	−.5	.5	−.4	−2.2	58.1	−47.0
Other entitlements and mandatories	7.0	11.4	40.9	65.2	84.7	70.4	98.0
Net interest	8.6	14.4	23.2	52.5	129.4	183.8	236.1
Total	118.2	195.6	332.3	590.9	946.3	1,251.9	1,484.2
Memo: GNP	672.6	990.2	1,522.5	2,670.6	3,952.4	5,405.6	7,246.0
	As a percent of GNP						
National Defense	7.5	8.3	5.7	5.0	6.4	5.5	4.0
International discretionary	.8	.5	.6	.5	.4	.4	.3
Domestic discretionary	4.0	4.1	4.9	5.2	3.9	3.4	3.2
Subtotal, discretionary	12.3	12.8	11.1	10.7	10.8	9.3	7.5
Social Security	2.5	3.0	4.1	4.4	4.7	4.6	4.6
Medicare	.0	.7	.9	1.3	1.8	2.0	2.4
Medicaid	.0	.3	.4	.5	.6	.8	1.2
AFDC, SSI, Food Stamps	.4	.5	.9	.8	.8	.7	.8
Deposit insurance	−.1	−.1	.0	.0	−.1	1.1	−.7
Other entitlements and mandatories	1.0	1.2	2.7	2.4	2.1	1.3	1.4
Net interest	1.3	1.5	1.5	2.0	3.3	3.4	3.3
Total	17.6	19.8	21.8	22.1	23.9	23.2	20.5
Memo: Social Security, Medicare and Medicaid	2.6	3.9	5.5	6.2	7.1	7.3	8.2
	As a percent of budget						
National Defense	42.8	41.8	26.0	22.7	26.7	23.9	19.5
International discretionary	4.7	2.3	2.5	2.2	1.8	1.5	1.4
Domestic discretionary	22.7	20.8	22.5	23.6	16.4	14.9	15.7
Subtotal, discretionary	70.1	64.8	51.0	48.5	44.9	40.3	36.6
Social Security	14.5	15.0	19.0	19.8	19.7	19.7	22.6
Medicare	.0	3.5	4.2	5.7	7.4	8.6	11.7
Medicaid	.3	1.4	2.0	2.4	2.4	3.3	5.7
AFDC, SSI, Food Stamps	2.4	2.4	4.2	3.8	3.2	3.2	4.1
Deposit insurance	−.3	−.3	.2	−.1	−.2	4.6	−3.4
Other entitlements and mandatories	5.9	5.8	12.3	11.0	9.0	5.6	6.8
Net interest	7.3	7.4	7.0	8.9	13.7	14.7	15.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[1] Projections for 1995 assume adherence to the discretionary caps agreed to in the Budget Enforcement Act (BEA); The BEA places a cap on total discretionary spending in 1995. Allocations for the 3 discretionary spending categories are based on the President's budget allocations.

Source: Congressional Budget Office.

CHART 1. MAJOR SPENDING CATEGORIES AS A PERCENT OF GNP—FISCAL YEARS. 1965. 1975. 1985. 1995



Note: 1995 numbers are CBO baseline projections.

TABLE 6.—COMPARISON OF CBO ACTUAL AND BASELINE PROJECTIONS TO 1980 AND 1985 SPENDING ADJUSTED FOR POPULATION AND PRICES

[By fiscal year, in billions]

	1980	1985	1990	1995
CBO Baseline Projections				
National defense	134.0	252.7	299.3	289.0
Social Security	117.1	186.5	246.5	335.4
Medicare	33.9	69.8	107.4	173.6
Medicaid	14.0	22.7	41.1	84.1
AFDC, SSI, food stamps	22.2	30.4	39.7	60.8
Other entitlements and mandatories [1]	65.2	84.7	70.4	98.0
Nondefense discretionary	152.4	172.3	205.5	254.2
Net interest	52.5	129.4	183.8	236.1
Total [1]	591.3	948.5	1,193.7	1,531.2

Increases in Spending if Adjusted for Only Price and Population Changes Since 1980

	1990	Different from baseline	1995	Different from baseline
National defense	237.4	61.9	298.9	−9.9
Social Security	207.5	39.0	261.2	74.2
Medicare	60.1	47.3	75.6	98.0
Medicaid	24.8	16.3	31.2	52.9
AFDC, SSI, food stamps	39.3	0.4	49.5	11.3
Other entitlements and mandatories [1]	115.5	−45.1	145.4	−47.4
Nondefense discretionary	270.0	−64.5	339.9	−85.7
Net interest	93.0	90.8	117.1	119.0
Total [1]	1047.7	146.0	1319.0	212.2

TABLE 6.—COMPARISON OF CBO BASELINE PROJECTIONS TO 1980 AND 1985 SPENDING ADJUSTED FOR POPULATION AND PRICES—Continued

Increases in Spending if Adjusted for Only Price and Population Changes Since 1985

	1990	Different from baseline	1995	Different from baseline
National defense	320.3	−21.0	403.2	−114.2
Social Security	236.4	10.1	297.6	37.8
Medicare	88.5	18.9	111.4	62.2
Medicaid	28.8	12.3	36.2	47.9
AFDC, SSI, food stamps	38.5	1.2	48.5	12.3
Other entitlements and mandatories [1]	107.3	−36.9	135.1	−37.1
Nondefense discretionary	218.4	−12.9	274.9	−20.7
Net interest	164.0	19.8	206.5	29.6
Total [1]	1,202.1	−8.4	1,513.3	17.9

Increases in Spending if Same Percent of GNP as in 1980

	1990	Different from baseline	1995	Different from baseline
National defense	271.2	28.1	363.6	−74.6
Social Security	237.0	9.5	317.7	17.7
Medicare	68.6	38.8	92.0	81.6
Medicaid	38.2	28.3	38.0	46.1
AFDC, SSI, food stamps	44.9	−5.2	60.2	0.6
Other entitlements and mandatories [1]	132.0	−61.6	176.9	−78.9
Nondefense discretionary	308.5	−103.0	413.5	−159.3
Net interest	106.3	77.5	142.4	93.7
Total [1]	1,196.9	−3.2	1,604.3	−73.1

[1] Based upon table 5 in this section. Total and other entitlements and mandatories do not include deposit insurance outlays.

Note: This table illustrates the increases in spending if government expenditures in major categories had been increased for prices and population. This table blindly assumes that spending should stay the same in real per capita terms or the same percentage of GNP. The methodology does not take into account medical price increases different from inflation, it does not account for defense policy needs nor for the fact that some programs serve populations growing faster than average. The price index chosen in this methodology is the CPI–X1. This table is primarily designed to illustrate which major spending programs are growing faster than prices and population and which categories are growing more slowly. If 1980 is chosen as a base year, defense spending would have grown to $298.9 billion in fiscal year 1995 compared to $289.0 billion in the CBO baseline. Projections for 1995 assume adherence to the discretionary caps agreed to in the Budget Enforcement Act (BEA). The BEA places a cap on total discretionary spending in 1995. Allocations for Defense and Nondefense discretionary spending are based on the President's budget allocations. Defense outlays for 1980, 1985, and 1990 include a small amount of mandatory spending. The mandatory portion of defense for 1995 is included in "other entitlements and mandatories." Totals may not add due to rounding.

Source: Committee staff, based on CBO projections.

TABLE 7.—MAJOR POLICY CHANGES IN WAYS AND MEANS COMMITTEE PROGRAMS (BUDGETARY SAVINGS ESTIMATES FOR FISCAL YEAR 1993)

	Dollars in billions	Percent [1]
Social Security:		
6-month COLA delay [2]	$4.5	
Taxation of benefits	6.1	
Elimination of students benefits	2.6	
Elimination of certain mother/father benefits	.8	
Elimination of minimum benefits	.3	
Disability insurance:		
6-month COLA delay	.5	
Taxation of benefits	.2	
Limit on family maximum	1.1	
Assume 1971–80 award rate continued through 1993 [3]	10.7	
Subtotal—Social Security	26.8	8
Medicare:		
Provider reductions [4]	51.1	27
Deductible increases	2.3	
Part B premium increases [5]	8.1	
Subtotal	61.5	
AFDC:		
Real benefit decline since 1975 [6]	8.6	
Earnings disregard and other charges	.7	
Subtotal	9.3	36
Title XX (Social Services Block Grant):		
Real decline in budget authority [7]	3.3	54
Unemployment compensation:		
Decline in State coverage [8]	.9	
Taxation of benefits [9]	2.2	
Subtotal	3.0	
SSI:		
Benefit increase in July 1983 [10]	+1.1	
Child welfare services	NA	
Trade adjustment assistance	NA	
Total changes	102.8	
Total change in outlays	94.2	
Total changes in benefits to individuals	51.6	

---

[1] Calculated as savings/(savings plus fiscal year 1993 outlays).

[2] This illustrates that the provision to tax 50 percent of Social Security benefits above $25,000 for a single individual and $32,000 of a married couple filing jointly indirectly cut Social Security benefits.

[3] These savings are due mostly to administrative policy. The savings of $10.7 billion are derived by assuming that the new award rate that prevailed during the 1970's would continue throughout all of the 1980's.

[4] The Medicare provider reductions and the deductible increases are derived by assuming that the real increase in expenditures per Medicare beneficiary that prevailed from 1975 to 1980 would continue into the 1980's. See appendix B in the section entitled "Analyzing Trends in Medicare Spending, 1967–1996" for a more complete discussion of how this savings estimate was attained.

[5] This shows the increase in part B premiums that took place as a result of maintaining part B premiums at 25 percent of the total cost of the part B program. During the 1970's part B premiums increased at a rate equal to the increase in the Social Security COLA.

[6] This estimate is derived by assuming that States would have held their AFDC benefit level in real terms equal to that in 1975.

[7] This estimate is a result of the real decline in title XX (Social Security Block Grant) program using the CPI-X1 price index. It compares 1977 real budget authority to that in 1993.

[8] This savings estimate is derived by assuming that the ratio of insured unemployed workers to job losers would be at the same ratio as that prevailing in 1979.

[9] This savings estimate shows the amount of money derived by taxing unemployment benefits.

[10] This number illustrates the additional cost in fiscal year 1993 of the $20-per-month increase in the SSI benefit for individuals and the $30-per-month increase for couples.

Note.—This table illustrates the savings for fiscal year 1993 for the major changes in policy that occurred between 1980 and 1990 for the entitlement programs under the jurisdiction of the Committee on Ways and Means. For example, if the 6-month cost-of-living allowance delay had not been enacted in the 1983 Social Security amendments, Social Security outlays would be $4.5 billion larger in fiscal year 1993. This table does not attempt to differentiate between legislative changes made at the Federal and the State level nor does it attempt to differentiate between regulation and law. It is an effort to illustrate precisely the magnitude of entitlement savings that actually occurred due to policy changes at the Federal and State level. It also makes no judgment about whether these policy changes were appropriate.

Source: Committee Staff based upon CBO technical assistance.

TABLE 8.—CBO BASELINE OUTLAY PROJECTIONS FOR MAJOR SPENDING CATEGORIES

[By fiscal year]

Spending category	Actual 1990	Base 1991	Projected 1992	1993	1994	1995	1996
			In billions of dollars				
Defense	299.3	300.9	295.8	292.5	(1)	(1)	(1)
International	19.1	18.7	19.6	20.4	(1)	(1)	(1)
Domestic	−19.1	199.2	212.1	224.7	(1)	(1)	(1)
Discretionary	299.3	518.8	527.5	537.6	537.8	543.2	562.6
Desert Storm		8.2	4.6	0.8	0.4	0.0	0.0
Mandatory	563.2	572.2	624.2	664.0	706.2	751.8	801.3
Deposit Insurance	58.1	103.4	97.3	47.3	24.6	−47.0	−42.8
Net Interest	183.8	198.9	209.8	222.1	231.7	236.1	240.0
Total Outlays	1,104.4	1,401.6	1,463.4	1,471.8	1,500.7	1,484.2	1,561.2
			As a percentage of GNP				
Defense	5.5	5.4	4.9	4.6	(1)	(1)	(1)
International	0.4	0.3	0.3	0.3	(1)	(1)	(1)
Domestic	−0.4	3.5	3.5	3.5	(1)	(1)	(1)
Discretionary	5.5	9.2	8.8	8.4	7.9	7.5	7.3
Desert Storm	0.0	0.1	0.1	0.0	0.0	0.0	0.0
Mandatory	10.4	10.2	10.4	10.4	10.4	10.4	10.4
Deposit Insurance	1.1	1.8	1.6	0.7	0.4	−0.6	−0.6
Net Interest	3.4	3.5	3.5	3.5	3.4	3.3	3.1
Total Outlays	20.4	24.9	24.4	23.0	22.0	20.5	20.3

[1] Projections for 1992–1996 assume adherence to the discretionary caps agreed to in the Budget Enforcement Act (BEA); the BEA caps total discretionary spending beginning in 1994.

Source: Congressional Budget Office.

TABLE 9.—COMPONENTS OF CBO BASELINE SPENDING PROJECTIONS

[By fiscal year, in billions of dollars]

	1992	1993	1994	1995	1996
1991 level	1,402	1,402	1,402	1,402	1,402
Changes in mandatory programs:					
Cost-of-living adjustments [1]	14	30	45	60	75
Increases in caseloads	7	17	27	38	49
Increases in costs of medical care [1]	5	11	20	32	45
Increases in use of medical care [2]	11	20	31	41	52
Rising benefits for new Social Security beneficiaries [2]	5	6	9	12	15
Changes in deposit insurance	−6	−56	−79	−150	−146
Increased interest costs	11	23	33	38	41
Other changes	10	7	2	−4	−7
Subtotal	57	59	88	66	124
Changes in discretionary programs:					
Defense [3]	−9	−16	(4)	(4)	(4)
International	1	2	(4)	(4)	(4)
Domestic	13	26	(4)	(4)	(4)
Subtotal	5	11	11	16	36
Total increases	62	70	99	83	160
CBO baseline assuming discretionary caps	1,463	1,472	1,501	1,484	1,561

[1] Represents program growth that could be eliminated by freezing cost-of-living adjustments and certain medical reimbursement rates.

[2] All growth not explained by increases in caseloads and prices.

[3] Includes Operation Desert Storm.

[4] Discretionary spending caps are specified by category through 1993 and in the aggregate for 1994 and 1995. The 1996 figure is a baseline projection.

Source: Congressional Budget Office.

TABLE 10.—FEDERAL REVENUES BY SOURCE FOR SELECTED YEARS IN NOMINAL DOLLARS, AS A PERCENT OF GNP AND TOTAL REVENUES

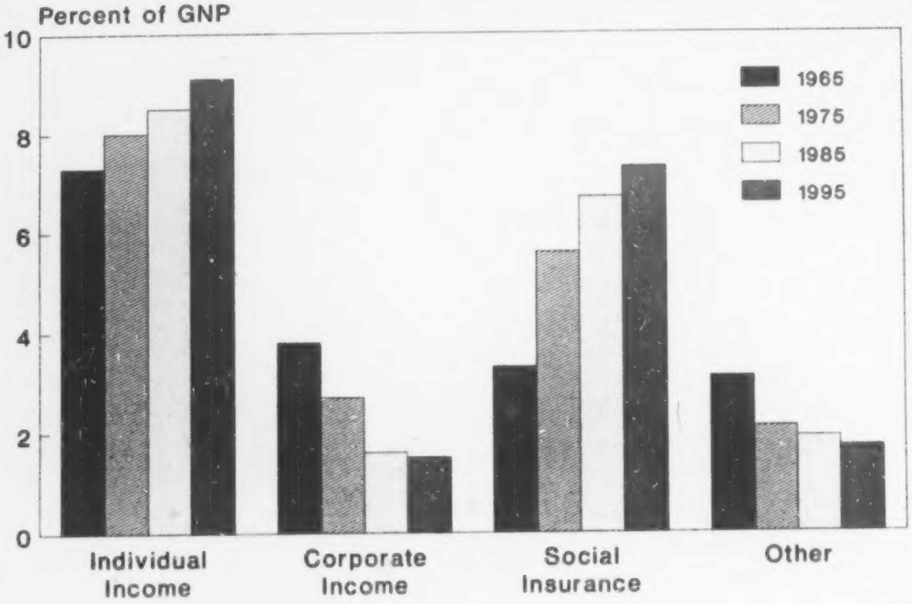
[By fiscal year]

	1965	1970	1975	1980	1985	1990	1995
	In nominal dollars (billions)						
Individual income	48.8	90.4	122.4	244.1	334.5	466.9	659.5
Corporate income	25.5	32.8	40.6	64.6	61.3	93.5	109.2
Social insurance	22.2	44.4	84.5	157.8	265.2	380.0	527.9
Excise	14.6	15.7	16.6	24.3	36.0	35.3	56.0
Estate and gift	2.7	3.6	4.6	6.4	6.4	11.5	14.3
Other	3.0	5.9	10.4	19.9	30.6	44.0	48.4
Total	116.8	192.8	279.1	517.1	734.1	1,031.3	1,415.4
	As a percent of GNP						
Individual income	7.3	9.1	8.0	9.1	8.5	8.6	9.1
Corporate income	3.8	3.3	2.7	2.4	1.6	1.7	1.5
Social insurance	3.3	4.5	5.6	5.9	6.7	7.0	7.3
Excise	2.2	1.6	1.1	.9	.9	.7	.8
Estate and gift	.4	.4	.3	.2	.2	.2	.2
Other	.5	.6	.7	.7	.8	.8	.7
Total	17.4	19.5	18.3	19.4	18.6	19.1	19.5
	As a percent of revenues						
Individual income	41.8	46.9	43.9	47.2	45.6	45.3	46.6
Corporate income	21.8	17.0	14.6	12.5	8.4	9.1	7.7
Social insurance	19.0	23.0	30.3	30.5	36.1	36.9	37.3
Excise	12.5	8.1	5.9	4.7	4.9	3.4	4.0
Estate and gift	2.3	1.9	1.7	1.2	.9	1.1	1.0
Other	2.6	3.0	3.7	3.9	4.2	4.3	3.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[1] Projected (CBO revised baseline).

Source: Congressional Budget Office, "The Economic and Budget Outlook: Fiscal Years 1992–1996."

CHART 3. FEDERAL REVENUES AS A PERCENT OF GNP—FISCAL YEARS 1965, 1975, 1985, AND 1995



Note: 1995 numbers are CBO baseline projections.

TABLE 11.—CBO BASELINE REVENUE PROJECTIONS BY SOURCE, AND AS A PERCENT OF GNP, 1990–96

[By fiscal year]

	1990 actual	1991 base	Projections				
			1992	1993	1994	1995	1996
			In billions of dollars				
Individual income	466.9	488.3	528.7	568.8	612.0	659.5	705.0
Corporate income	93.5	99.1	103.1	107.0	108.6	109.2	111.1
Social insurance	380.0	404.1	432.8	463.7	496.0	527.9	559.9
Excise	35.3	45.7	49.3	52.7	54.4	56.0	54.1
Estate and gift	11.5	12.1	12.8	13.5	13.6	14.3	15.1
Customs duties	16.7	17.3	18.0	19.6	21.0	22.2	23.7
Other	27.3	26.2	24.6	25.5	26.0	26.2	26.5
Total	1,031.3	1,092.8	1,169.2	1,250.7	1,331.5	1,415.4	1,495.4
			As a percent of GNP				
Individual income	8.6	8.7	8.8	8.9	9.0	9.1	9.1
Corporate income	1.7	1.8	1.7	1.7	1.6	1.5	1.4
Social insurance	7.0	7.2	7.2	7.2	7.3	7.3	7.3
Excise	.7	.8	.8	.8	.8	.8	.7
Estate and gift	.2	.2	.2	.2	.2	.2	.2
Customs duties	.3	.3	.3	.3	.3	.3	.3
Other	.5	.5	.4	.4	.4	.4	.3
Total	19.1	19.4	19.5	19.5	19.5	19.5	19.4

Source: Congressional Budget Office.

TABLE 12.—CBO BASELINE PROJECTIONS FOR PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS FOR FISCAL YEARS 1989–96

[By fiscal year, in billions of dollars]

	1989 actual	1990 actual	1991	1992	1993	1994	1995	1996
Social Security	230.4	246.5	266.0	284.3	301.1	317.9	335.4	353.7
OASI	207.7	222.0	239.2	255.2	270.4	285.2	300.8	317.0
DI	22.7	24.4	26.7	28.9	30.7	32.6	34.6	36.7
Medicare	94.3	107.4	114.0	127.0	140.2	155.9	173.6	193.8
HI	57.4	65.9	69.0	76.5	83.2	91.8	101.2	111.7
SMI	36.9	41.5	45.0	50.5	57.0	64.1	72.4	82.0
Trade adjustment	.2	.1	.2	.2	.2	.2	.2	.2
Unemployment insurance	14.0	17.4	23.8	21.3	20.7	21.2	21.4	21.5
Family support	11.2	11.5	14.3	15.6	16.4	17.2	18.1	18.6
EITC—outlays	4.0	4.4	4.7	6.3	7.3	8.0	10.2	10.6
SSI	11.5	11.5	14.9	16.3	17.2	19.9	19.9	19.6
Title XX—social services	2.7	2.7	2.8	2.8	2.8	2.8	2.8	2.8
Child welfare	.2	.3	.3	.3	.3	.3	.3	.3
Foster care and adoption assessment	1.3	1.6	2.5	2.7	2.9	3.4	3.9	4.5
Child health insurance credit	.0	.0	.1	1.0	1.1	1.2	1.2	1.3
SMI premium	11.6	11.6	11.8	12.9	14.8	16.9	19.1	20.5
Total	381.3	415.0	455.4	490.8	524.9	564.7	606.4	647.5

Note: All figures represent entitlement or mandatory spending except child welfare, which is discretionary, and SMI premiums, which are offsetting collections.

TABLE 13.—WAYS AND MEANS PROGRAM OUTLAYS COMPARED WITH TOTAL FEDERAL GOVERNMENT OUTLAYS, IN NOMINAL DOLLARS, AND AVERAGE ANNUAL GROWTH RATES FOR SELECTED YEARS

	Fiscal year					
	1970	1975	1980	1985	1990	1995
	In nominal dollars (billions)					
Social Security [1]	29.4	63.1	117.1	186.5	246.5	335.4
Medicare [1]	6.8	14.1	33.9	69.8	107.4	173.6
Unemployment compensation and trade adjustment assistance [1]	2.8	12.0	15.7	16.0	17.5	21.7
Public assistance and social services (Family Support Administration, SSI, Title XX, EITC, and Foster Care)	5.1	13.5	17.8	23.3	32.0	57.7
Other entitlement and mandatories	10.8	35.1	63.7	95.0	156.2	163.5
Deposit insurance	−.5	−.5	−.4	−2.2	58.1	−47.0
Nondefense discretionary spending	45.1	84.3	156.3	175.8	205.5	254.2
National defense	81.7	86.5	134.0	252.7	299.3	289.0
Net interest	14.4	23.2	52.5	129.4	129.4	236.1
Total	195.6	332.3	590.9	946.3	1,251.9	1,484.2
Memo: CPI–X1	40.3	54.2	80.1	106.6	127.7	157.5

	Average annual growth rates				
	1970–75	1975–80	1980–85	1985–90	1990–95
Social Security [1]	16.5	13.2	9.8	5.7	8.0
Medicare [1]	15.7	19.2	15.5	9.0	12.8
Unemployment compensation and trade adjustment assistance [1]	33.8	5.5	.5	1.8	5.5
Public assistance and social services (Family Support Administration, SSI, Title XX, EITC, and Foster Care)	21.5	5.7	5.5	6.6	15.9
Other entitlement and mandatories	19.3	12.0	8.7	10.5	1.1
Deposit insurance	NA	NA	NA	NA	NA
Nondefense discretionary spending	13.6	12.9	2.3	3.2	5.5
National defense	1.1	9.1	13.5	3.4	−.9
Net interest	10.0	17.7	19.8	.0	16.2
Total	11.2	12.2	9.9	5.8	4.3
Memo: CPI–X1	6.1	8.1	5.9	3.9	5.0

[1] Includes entitlement spending only.

Source: Congressional Budget Office.

TABLE 14.—WAYS AND MEANS PROGRAM OUTLAYS COMPARED WITH TOTAL FEDERAL PROGRAM OUTLAYS IN PERCENTAGE TERMS FOR SELECTED YEARS

	1970	1975	1980	1985	1990 [1]	1995 [1]
Social Security (including medicare)	19.2	24.5	26.6	27.7	28.3	34.3
Unemployment compensation and trade adjustment assistance	1.7	4.1	2.8	1.9	1.4	1.5
Public assistance and social services (AFDC, SSI, title XX, EITC, low income energy assistance and child welfare programs)	2.6	4.2	3.1	2.5	2.6	3.9
Other entitlement and mandatories	5.5	10.6	10.8	10.0	12.5	11.0
Deposit insurance	−.3	−.2	−.1	−.2	4.6	−3.2
Nondefense discretionary spending	22.3	23.3	24.5	18.2	16.4	17.1
National defense	41.7	26.7	23.2	26.7	23.9	19.5
Net interest	7.4	7.2	9.1	13.7	10.3	15.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
Ways and Means programs as percent of total Federal Government outlays, less interest	25.3	35.3	35.7	37.8	33.1	40.9

[1] Based on CBO baseline current law projections.

TABLE 15.—HISTORICAL OUTLAYS FOR ENTITLEMENTS AND OTHER MANDATORY SPENDING

[In billions of dollars]

Category	1975	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Means-tested programs:												
Stafford loans [1]	0.1	1.4	2.3	3.0	2.6	3.2	3.5	3.3	2.5	2.8	3.9	4.4
Medicaid	6.8	14.0	16.8	17.4	19.0	20.1	22.7	25.0	27.4	30.5	34.6	41.1
Food stamps	4.6	9.1	11.3	11.0	12.7	12.4	12.5	12.4	12.4	13.1	13.7	15.9
Child nutrition	1.5	3.4	3.4	3.0	3.3	3.5	3.7	3.8	4.0	4.3	4.6	5.0
Earned income tax credit		1.3	1.3	1.2	1.2	1.2	1.1	1.4	1.4	2.7	4.0	4.4
Supplemental security income	4.4	5.7	6.5	6.9	7.9	7.6	8.7	9.3	9.9	11.4	11.5	11.5
Family support	5.1	7.3	8.2	8.0	8.4	8.9	9.2	9.9	10.5	10.8	11.2	12.5
Veterans' pensions	2.7	3.6	3.8	3.9	3.9	3.9	3.8	3.9	3.8	3.9	4.0	3.6
Other	.1	.2	.4	.3	.4	.5	.8	.8	.8	1.0	1.4	1.6
Total, means-tested programs	25.4	45.9	53.9	54.8	59.3	61.3	66.0	69.9	72.9	80.5	88.8	99.9
Non-means-tested programs:												
Medicare	14.1	33.9	41.3	49.2	55.5	61.0	69.8	74.2	79.9	85.7	94.3	107.4
Social Security	63.1	117.1	137.9	154.1	168.6	176.1	186.5	196.7	205.2	217.1	230.1	246.5
Subtotal	77.2	151.0	179.2	203.3	224.1	237.1	256.3	270.9	285.2	302.8	324.4	353.9
Other retirement and disability:												
Federal civilian [3]	7.4	15.5	18.6	20.6	22.1	23.3	24.6	25.0	27.6	30.3	31.8	33.7
Military	6.2	11.9	13.7	14.9	15.9	16.5	15.8	17.6	18.1	19.0	20.2	21.5
Other	3.0	4.7	5.0	5.2	5.1	4.9	5.1	4.9	5.1	4.8	5.2	4.7
Subtotal	16.6	32.1	37.4	40.7	43.2	44.7	45.5	47.5	50.8	54.2	57.2	59.9

Other programs:												
Unemployed compensation	12.8	16.9	18.3	22.2	29.7	16.8	15.8	16.1	15.5	13.6	13.9	17.5
Deposit insurance	.5	−.4	−1.4	−2.2	−1.2	−.9	−2.2	1.5	3.1	10.0	22.0	58.1
Farm price supports	.6	2.8	4.0	11.7	18.9	7.3	17.7	25.8	22.4	12.2	10.6	6.5
Social services	2.9	3.7	3.9	3.4	3.5	4.4	3.5	4.0	4.1	4.2	4.6	5.1
Veterans benefits [3]	10.2	11.0	12.2	12.5	12.7	12.8	12.9	12.9	13.0	14.8	14.9	13.4
General revenue sharing	6.1	6.8	5.1	4.6	4.6	4.6	4.6	5.1				
Other	5.7	12.4	13.7	7.8	6.2	9.1	22.5	4.2	7.1	12.5	10.1	6.2
Subtotal	25.5	36.8	38.9	39.9	45.9	38.2	61.2	52.0	46.6	43.7	40.1	31.1
Total, Non-means-tested programs	132.7	236.4	272.4	304.0	341.6	335.9	376.6	388.1	401.2	424.3	457.7	520.5
Total outlays	158.0	282.3	326.3	358.8	400.9	397.2	442.6	458.0	474.1	504.7	546.6	620.4

---

[1] Formerly known as Guaranteed Student Loans.

[2] Includes Civil Service, Foreign Service, Coast Guard, other retirement programs, and annuitants' health benefits.

[3] Includes veterans compensation, readjustment benefits, life insurance, and housing programs.

Source: Congressional Budget Office.

TABLE 16.—COMPARISON OF AVERAGE ANNUAL GROWTH RATES FOR MAJOR ENTITLEMENT AND MANDATORY SPENDING PROGRAMS FOR SELECTED TIME PERIODS, BASED ON VARIOUS ADJUSTMENTS FOR INFLATION AND POPULATION GROWTH

Between years adjusted for	1975–90 [1]	1975–90 [2]	1975–90 [2 3]	1975–81 [2 3]	1981–89 [2 3]	1981–89 [2 4]
Means-tested programs:						
Medicaid	12.7	6.4	5.4	6.1	4.0	5.3
Food stamps [5]	8.6	2.5	1.5	6.0	−2.7	−1.7
Supplemental security income	6.6	6	−.4	−2.6	2.1	3.9
AFDC and child support enforcement	5.6	−.3	−1.3	−1.3	−1.2	−1.4
Veteran's pensions	1.9	−3.8	−4.7	−3.4	−4.4	−2.6
Child nutrition	8.4	2.3	1.3	4.6	−1.3	−.1
Guaranteed student loans	28.7	21.5	20.3	53.9	1.5	4.4
Other	20.3	13.6	12.4	12.8	11.1	11.1
Subtotal	9.5	3.4	2.4	3.5	1.1	2.2
Non-means-tested programs:						
Social Security	9.5	3.4	2.3	3.9	1.3	.2
Medicare	14.5	8.1	7.0	9.1	5.4	4.2
Subtotal	10.7	4.5	3.4	5.0	2.3	1.2
Other retirement and disability:						
Federal civilian [6]	10.6	4.4	3.4	6.4	1.6	.5
Military	8.6	2.6	1.5	4.1	−.2	−1.3
Other	3.0	−2.7	−3.7	−.7	−4.5	−5.6
Subtotal	8.9	2.8	1.8	4.4	.2	−.9
Unemployment compensation	2.1	−3.6	−4.6	−3.2	−8.2	−4.5
Other programs:						
Veterans' benefits [7]	1.8	−3.9	−4.8	−6.0	−2.6	−3.6
Farm price supports	17.2	10.6	9.5	25.2	7.3	7.3
General revenue sharing	−100.0	−100.0	−100.0	−11.5	−100.0	−100.0
Social services	3.8	−2.0	−3.0	−4.2	−3.0	−3.0
Other	1.1	−4.6	−5.6	−3.1	−5.6	−5.6
Subtotal	9.0	2.9	−1.9	−4.9	2.6	2.6
Total, non-means-tested programs	9.6	3.5	2.5	2.7	1.6	1.6
Total outlays	9.6	3.5	2.4	2.8	1.5	1.5

TABLE 16.—COMPARISON OF AVERAGE ANNUAL GROWTH RATES FOR MAJOR ENTITLEMENT AND MANDATORY SPENDING PROGRAMS FOR SELECTED TIME PERIODS, BASED ON VARIOUS ADJUSTMENTS FOR INFLATION AND POPULATION GROWTH—Continued

Between years adjusted for	1975–90 [1]	1975–90 [2]	1975–90 [2] [3]	1975–81 [2] [3]	1981–89 [2] [3]	1981–89 [2] [4]
Memo:						
Social Security, SSI, veterans' pensions and benefits	8.7	2.6	1.6	2.5	1.0	−0.2
Food stamps, AFDC, and child nutrition	7.3	1.3	.3	2.8	−1.9	−0.9
Medicare and Medicaid	14.0	7.6	6.5	8.2	5.0	3.8

[1] Nominal growth.

[2] Adjusted for inflation (based on the CPI–XI).

[3] Adjusted for overall population growth.

[4] Adjusted for population growth specific to each program category (e.g., Medicaid outlays adjusted for growth in the number of pre-transfer (means-tested) poor among the elderly and among families with children, Social Security and Medicare outlays adjusted for growth in the overall elderly population and AFDC outlays adjusted for growth in the number of pre-transfer (means-tested) poor among single parents with children).

[5] Includes nutrition assistance for Puerto Rico.

[6] Includes Coast Guard retirement.

[7] Includes veterans' compensation, readjustment benefits, life insurance, and housing projects.

TABLE 17.—CBO REVISED BASELINE PROJECTIONS FOR ENTITLEMENTS AND OTHER MANDATORY SPENDING CATEGORIES

[By fiscal year, in billions of dollars]

Category	1991 base	Projections				
		1992	1993	1994	1995	1996
Means-Tested Programs						
Medicaid	50.8	58.7	66.2	74.7	84.1	94.7
Food stamps [1]	18.9	20.5	21.0	22.0	22.8	23.5
Supplemental security income	14.9	16.3	17.2	19.9	19.9	19.6
Family support	14.3	15.6	16.4	17.2	18.1	18.6
Veterans' pensions	3.9	3.7	3.7	4.0	3.6	3.3
Child nutrition	5.3	5.8	6.2	6.6	7.0	7.5
Earned income tax credit	4.7	6.3	7.3	8.0	10.3	10.6
Stafford loans [2] [3]	4.3	2.0	2.7	2.7	2.8	2.8
Other	2.5	2.7	2.9	3.4	4.0	4.6
Total, means-tested programs	119.8	131.7	143.7	158.5	172.6	185.2
Non-Means-Tested Programs						
Social Security	266.0	284.3	301.1	317.9	335.4	353.7
Medicare	114.0	127.0	140.2	155.9	173.6	193.8
Subtotal	380.0	411.4	411.3	473.8	509.0	547.5
Other retirement and disability:						
Federal civilian [4]	36.9	38.6	40.4	43.1	45.8	51.3

TABLE 17.—CBO REVISED BASELINE PROJECTIONS FOR ENTITLEMENTS AND OTHER MANDATORY SPENDING CATEGORIES—Continued

[By fiscal year, in billions of dollars]

Category	1991 base	Projections				
		1992	1993	1994	1995	1996
Military	23.1	24.6	26.0	27.4	28.8	30.4
Other	4.7	5.2	5.1	5.1	5.1	5.1
Subtotal	64.7	68.5	71.5	75.6	79.8	86.8
Unemployment compensation	23.7	21.1	20.6	21.0	21.3	21.3
Deposit insurance	103.4	98.0	47.6	25.0	−49.9	−47.1
Other programs:						
Veterans benefits [3] [5]	14.8	15.3	15.9	17.5	16.9	16.2
Farm price supports [3]	10.4	11.4	10.2	9.7	9.2	8.9
Social services	5.6	5.6	5.5	5.2	5.1	5.1
Credit reform liquidating accounts [3]	0.0	11.8	9.0	5.3	2.7	−3.7
Other	13.5	10.9	13.2	9.7	12.1	14.5
Subtotal	44.3	54.9	53.7	47.5	45.9	41.0
Total, non-means-tested programs	616.1	653.8	634.7	642.8	606.2	649.6
Total outlays	735.9	785.5	778.4	801.3	778.7	834.8

[1] Includes nutrition assistance to Puerto Rico.

[2] Formerly known as Guaranteed Student Loans.

[3] Program affected by credit reform.

[4] Includes Civil Service, Foreign Service, Coast Guard, other retirement programs, and annuitants' health benefits.

[5] Includes veterans compensation, readjustment benefits, life insurance, and housing programs.

Note: Spending for major benefit programs shown in this table includes benefits only. Outlays for administrative costs of most benefit programs are classified as nondefense discretionary spending, and Medicare premium collections are offsetting receipts.

Source: Congressional Budget Office.

TABLE 18.—CHANGES IN LOW INCOME DISCRETIONARY PROGRAM FUNDING, FISCAL YEARS 1981–91

[Budget authority, in millions of dollars]

	Fiscal year 1981 actual	Fiscal year 1981 inflated [1]	Fiscal year 1991	Fiscal year 1991—1981 inflated	Percent change
Education					
Compensatory education	3,112	4,596	6,225	1,628	35.4
Education for the homeless [2] [3]	0	0	17	17	NA
Financial aid	3,802	5,616	6,714	1,097	19.5
Head Start	814	1,202	1,952	749	62.3
Higher education (TRIOS)	156	231	334	103	44.5
Indian Education	345	510	620	110	21.6
Subtotal education	8,229	12,156	15,861	3,705	30.5
Nutrition					
Commodity supplemental food program	28	41	82	41	101.5
Food donation programs	129	190	228	38	20.0
Temporary emergency food assistance	0	0	170	170	NA
WIC supplemental food program	900	1,329	2,350	1,021	76.9
Subtotal nutrition	1,056	1,559	2,830	1,271	81.5
Housing					
Emergency food and shelter [2]	0	0	134	134	NA
Emergency shelter grants [2]	0	0	73	73	NA
Housing elderly/handicapped [4]	831	1,228	657	−571	−46.5
Public housing operating subsidies	1,071	1,582	2,100	518	32.7
Rural housing insurance fund [5]	3,896	5,755	1,879	−3,876	−67.4
Additional rural housing [6]	453	669	363	−306	−45.7
Section 8 homeless SRO's [2]	0	0	105	105	NA
Subsidized housing	30,170	44,566	8,868	−35,698	−80.1
Subsidized housing renewals	0	0	7,735	7,735	NA
Transitional and supporting housing [2]	0	0	150	150	NA
Subtotal housing	36,421	53,800	22,064	−31,736	−59.0
Health					
Community health centers	338	500	443	−57	−11.3
Health care homeless [2]	0	0	51	51	NA
Immunizations	44	65	218	152	232.5
Maternal and child health	448	661	587	−74	−11.2
Migrant health	42	62	52	−10	−15.9
Homeless mental health [2, 7]	0	0	55	55	NA
Indian health	607	896	1,411	515	57.5
Indian health facilities	83	123	166	44	35.6
Subtotal health	1,562	2,307	2,984	677	29.3

TABLE 18.—CHANGES IN LOW INCOME DISCRETIONARY PROGRAM FUNDING, FISCAL YEARS 1981–91—Continued

[Budget authority, in millions of dollars]

	Fiscal year 1981 actual	Fiscal year 1981 inflated [1]	Fiscal year 1991	Fiscal year 1991—1981 inflated	Percent change
Employment					
Job training welfare recipients [8]	365	539	700	161	29.8
Older Americans employment	277	409	390	−19	−4.6
Training and employment services	7,574	11,188	4,079	−7,109	−63.5
Subtotal employment	8,216	12,136	5,170	−6,967	−57.4
Other					
Child welfare services	174	257	274	17	6.7
Community development block grant	3,695	5,458	3,200	−2,258	−41.4
Community services block grant [9]	525	776	436	−340	NA
Legal services	321	475	327	−147	−31.1
Low income energy assistance	1,850	2,732	1,610	−1,122	−41.1
Low income weatherization	175	259	199	−60	−23.0
Runaway and homeless youth	11	16	35	19	116.2
VISTA	33	49	36	−13	−26.9
Subtotal other	6,783	10,020	6,117	−3,903	−39.0
Total low income Discretionary	62,267	91,979	55,026	−36,953	−40.2
Total less subsidized housing	32,097	47,413	38,422	−8,990	−19.0

[1] Inflation from FY 1981 to FY 1991, calculated using the GNP deflator, is 47.72 percent.

[2] These programs are part of the Stewart B. McKinney Homeless Assistance Act.

[3] These programs include adult literacy, homeless children education grants, and exemplary grants.

[4] In FY 1991 a new capital grants program replaced the direct loan program for housing assistance for the elderly and handicapped. Therefore, the FY 1981 figure is a loan limitation, as loan limits provide the best measure of program activity for loan programs, and the FY 1991 figure is budget authority.

[5] This is a loan program. Therefore, levels listed are loan limits instead of budget authority.

[6] These programs include domestic farm labor housing, mutual and self-help housing, very low income housing repair grants, rural housing preservation grants and rural rental assistance.

[7] These programs include the homeless block grant, mental health demonstrations, and alcohol and drug abuse demonstrations, administered by the Alcohol, Drug Abuse and Mental Health Administration.

[8] The FY 1981 figure is budget authority for the discretionary WIN program. The FY 1991 is the obligation level for the entitlement JOBS program, which replaced WIN. While $1 billion was appropriated for JOBS in FY 1991, CBO estimates that states will only request $700 million.

[9] The FY 1981 figure is budget authority of the Community Services Administration which was dismantled in FY 1982 and replaced by the community services block grant. While these activities are similar they are not identical.

NA—Not applicable.

TABLE 19.—COMPARISON OF CBO, ADMINISTRATION AND BLUE CHIP ECONOMIC PROJECTIONS, CALENDAR YEARS 1990–96

	Estimated	Forecast		Projected			
	1990	1991	1992	1993	1994	1995	1996
Nominal GNP (billions):							
CBO	$5,468	$5,700	$6,107	$6,505	$6,919	$7,358	$7,824
Administration	$5,465	$5,689	$6,095	$6,536	$6,990	$7,451	$7,931
Real GNP (percentage change, year over year):							
CBO	.9	.0	3.3	2.9	2.8	2.7	2.7
Administration	.8	−.3	3.1	3.5	3.3	3.1	3.0
Blue Chip	.9	.1	2.5	2.7	2.7	2.5	2.6
Consumer Price Index [1] (percentage change, year over year):							
CBO	5.4	4.9	3.5	3.6	3.6	3.6	3.6
Administration	5.3	5.2	4.0	3.7	3.5	3.4	3.3
Blue Chip	5.4	4.6	4.0	4.3	4.2	4.1	4.0
GNP deflator (percentage change, year over year):							
CBO	4.2	4.3	3.7	3.5	3.5	3.5	3.5
Administration	4.2	4.4	3.9	3.6	3.5	3.4	3.3
Blue Chip	4.1	3.7	3.6	4.0	4.0	3.9	3.8
Unemployment rate: [2]							
CBO	5.5	6.8	6.4	6.2	6.0	5.8	5.6
Administration	5.4	6.7	6.6	6.2	5.8	5.4	5.1
Blue Chip	5.5	6.5	6.3	5.7	5.5	5.4	5.3
3-month Treasury bill rate (percent):							
CBO	7.5	6.6	7.0	6.7	6.3	5.9	5.7
Administration	7.5	6.4	6.0	5.8	5.6	5.4	5.3
Blue Chip	7.5	6.0	6.3	6.9	6.9	6.8	6.7
10-year Government note rate (percent): [3]							
CBO	8.6	7.9	7.7	7.6	7.4	7.3	7.2
Administration	8.5	7.5	7.2	6.8	6.6	6.4	6.3
Blue Chip	8.5	7.8	8.0	8.1	7.9	7.8	7.7

---

[1] Consumer price index for all urban consumers (CPI–U) for CBO and the Blue Chip consumer price index for urban wage earners and clerical workers (CPI–W) for the Administration.

[2] The Administration's projection is for the total labor force, including armed forces residing in the United States, while the CBO projection is for the civilian labor force excluding armed forces. In recent years, the unemployment rate for the former has tended to be 0.1 to 0.2 percentage point below the rate for the civilian labor force alone.

[3] Blue Chip does not project a 10-year note rate. The values shown here are based on the Blue Chip projection of the Aaa bond rate, adjusted by CBO to reflect the estimated spread between Aaa bonds and 10-year government notes.

Sources: Congressional Budget Office, Office of Management and Budget, Eggert Economic Enterprises, Blue Chip Economic Indicators.

Note: The CBO forecast is based on data available through December 1990 and does not reflect fourth-quarter data for GNP or CPI published in January 1991. The Blue Chip forecasts through 1992 are based on a survey of 50 private forecasts published on February 10, 1991. The Blue Chip projections from 1993 through 1996 are based on a survey of 41 forecasts, published on October 10, 1990.

TABLE 20.—EFFECTS ON CBO BUDGET PROJECTIONS OF SELECTED CHANGES IN ECONOMIC ASSUMPTIONS

[By fiscal year, in billions of dollars]

	1991	1992	1993	1994	1995	1996
Real growth: Effect of 1-percentage-point lower annual rate beginning January 1991:						
Change in revenues	−7	−23	−40	−60	−80	−103
Change in outlays	1	4	8	14	21	31
Change in deficit	8	26	48	74	102	134
Change in revenues [1]	−28	−42	−43	−44	−46	−47
Individual	−17	−26	−28	−30	−32	−35
Corporate	−1	−3	−3	−3	−3	−3
Social insurance	−9	−12	−12	−10	−9	−8
Change in outlays	5	8	12	16	21	25
Unemployment Insurance	3	2	2	2	2	2
Means-tested benefits [2]	(3)	1	2	2	2	2
Debt service	1	4	8	12	17	21
Change in deficit	33	49	55	61	66	73
Inflation: Effect of 1-percentage-point higher annual rate beginning January 1991:						
Change in revenues	6	17	30	45	61	78
Change in outlays	5	18	30	43	57	71
Change in deficit	−1	[3]	−1	−2	−4	−7
Interest rates: Effect of 1-percentage-point higher annual rates beginning January 1991:						
Change in revenues	0	0	0	0	0	0
Change in outlays	5	15	22	28	33	37
Change in deficit	5	15	22	28	33	37

[1] Total includes other items not separately identified.

[2] Includes increased outlays for the Earned Income Tax Credit.

[3] Less than $500 million.

Source: Congressional Budget Office.

TABLE 21.—CHANGES IN CBO DEFICIT PROJECTIONS SINCE JULY

[By fiscal year, in billions of dollars]

	1991	1992	1993	1994	1995
July baseline	232	238	196	145	138
Changes:					
Policy changes:					
Revenues	−18	−33	−32	−37	−39
Entitlements and other mandatory spending	−9	−12	−16	−19	−19
Enacted appropriations	−6	−6	−9	−12	−13
Required reductions in discretionary spending	NA	−13	−22	−46	−62
Debt service saving	−1	−4	−10	−17	−27
Subtotal	−33	−69	−89	−131	−160
Economic assumptions	50	63	63	70	79
Technical reestimates:					
Deposit insurance	23	20	7	32	−44
Other	26	30	36	42	43
Subtotal	49	50	43	74	−1
Credit reform	0	2	3	2	(3)
Total changes	66	46	19	15	−81
CBO January 1991 baseline deficit [1]	298	284	215	160	57
Revisions:					
Revenues [2]	1	(3)	(3)	(3)	1
Desert Shield/Desert Storm	8	5	1	(3)	0
Sallie Mae repayments	(3)	(3)	(3)	(3)	(3)
Medicaid	2	2	3	3	4
Employer's share of employee retirement	0	1	2	3	5
Net interest [4]	−1	1	1	2	3
Other outlays	1	1	(3)	(3)	−1
Total	11	10	6	9	12
CBO March 1991 revised baseline deficit [1]	309	294	221	169	69

[1] Assumes compliance with discretionary caps.

[2] Revenue reductions are shown with a positive sign because they raise the deficit.

[3] Less than $500 million.

[4] Excludes the reclassifications of certain payments as net interest, which does not affect budget totals.

Notes: The projections include Social Security and the Postal Service, which are off-budget. n.a.=not applicable.

Source: Congressional Budget Office.

TABLE 22.—REVENUE IMPACT OF THE REVENUE PROVISIONS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

[Fiscal years 1991–95, in millions of dollars]

Item	Effective date	1991	1992	1993	1994	1995	1991–95
I. Revenue-losing provisions							
A. Extend expiring provisions through 12/31/91 [1]:							
1. Foreign allocation of R&D		−503	−289				−792
2. Research and experimentation tax credit		−602	−381	−105	−74	−47	−1,209
3. Employer-provided educational assistance (include graduate students)		−340	−128				−468
4. Employer-provided group legal services		−98	−29				−127
5. Targeted jobs tax credit		−81	−104	−676	−31	−20	−303
6. Business energy tax credits (solar and geothermal property)		−55	−28	3	2	1	−77
7. Low-income housing credit (with modifications)		−266	−355	−420	−420	−420	−1,881
8. Mortgage revenue bonds and mortgage credit certificates		−10	−50	−110	−100	−100	−370
9. Qualified small-issue manufacturing bonds		−10	−50	−80	−70	−70	−280
10. Health insurance for self-employed (25% deduction)		−253	−102				−355
11. Orphan drug tax credit		−4	−3				−7
Subtotals, extension of expiring provisions		−2,222	−1,519	−779	−693	−656	−5,869
B. Other tax incentives:							
1. Energy incentives:							
a. Extend nonconventional fuels tax credit (section 29) for two years and expand to tight sands gas.	1/1/91	−35	−115	−163	−152	−131	−597
b. Adopt tax incentives for ethanol production	1/1/91	16	18	−32	−89	−135	−221
c. Adopt 15% credit for enhanced oil recovery costs	1/1/91	−21	−42	−49	−50	−51	−213
d. Amend percentage depletion provisions	1/1/91	−24	−48	−61	−67	−78	−278
e. Cut back AMT preference for certain intangible drilling costs (IDCs)	1/1/91	−98	−188	−165	−154	−151	−756
f. Reduce AMT preference for percentage depletion on marginally producing properties.	1/1/91	−42	−84	−87	−92	−100	−404
2. Additional small business incentives:							
a. Modify estate freeze rules (section 2036(c))	10/9/90	12	−17	−126	−251	−393	−775

b. Disabled access expenditures:							
i. Adopt disabled persons access tax credit (50%/$5,000)	10/27/90	−50	−90	−92	−94	−96	−422
ii. Lower cap on section 190 expensing to $15,000	10/27/90	58	95	92	90	89	424
c. Repeal AMT preference for charitable contributions of tangible personal property (expires 12/31/91).	1/1/91	−8	−22	8	—	—	−22
Subtotals, other tax incentives	1/1/91	−192	−493	−675	−859	−1,046	−3,265
C. Progressivity enhancement provisions:							
1. Increase EITC and adjust for family size [2]	1/1/91	−75	−1,495	−2,091	−2,969	−5,730	−12,360
2. Child health insurance credit [3]	1/1/91	−58	−1,155	−1,239	−1,329	−1,426	−5,207
3. Supplemental EITC for taxpayers with children under one year old.[4]	1/1/91	−50	−160	−166	−173	−182	−731
Subtotals, progressivity enhancement provisions		−183	−2,810	−3,496	−4,471	−7,338	−18,298
Subtotals: Revenue-losing provisions		−2,597	−4,822	−4,950	−6,023	−9,040	−27,432
II. Revenue-raising provisions							
A. Deficit reduction provisions:							
1. Provisions affecting high-income taxpayers and itemized deductions:							
a. Individual rate structure: 15%/28%/31% (24% AMT rate; 28% maximum capital gains rate).	1/1/91	767	2,313	2,476	2,723	2,955	11,234
b. Phase out personal exemption (2%/$2,500; $100,000/$125,000/$150,000 thresholds; indexed) (5 year sunset).	1/1/91	1,046	2,028	2,275	2,552	2,863	10,764
c. Limit on itemized deductions of high-income taxpayers (3%; $100,000 threshold; indexed) (5 year sunset).	1/1/91	548	3,714	4,101	4,531	5,010	17,904
d. Eliminate medical deduction for cosmetic surgery	1/1/91	9	60	60	70	70	269
2. Impose 5-cent per gallon tax on motor fuels [5]	12/1/90	4,406	5,203	5,111	5,119	5,200	25,039
3. Double gas guzzler tax	1/1/91	75	95	85	70	60	385
4. Increase all tobacco excise taxes by 25% (e.g., for cigarettes 4 cents per pack in 1991 and 4 cents per pack in 1993).	1/1/91	542	792	1,546	1,519	1,477	5,876
5. Increase beer, wine, and distilled spirits excise taxes	1/1/91	1,300	1,850	1,862	1,874	1,882	8,768
6. Impose 10% luxury excise tax	1/1/91	25	65	426	461	502	1,479
7. Expand ozone-depleting chemicals excise tax	1/1/91	73	72	84	134	122	485
8. Extend Leaking Underground Storage Tank (LUST) Trust Fund excise tax (5 years).	12/1/90	94	122	124	126	128	593

TABLE 22.—REVENUE IMPACT OF THE REVENUE PROVISIONS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990—Continued

[Fiscal years 1991–95, in millions of dollars]

Item	Effective date	1991	1992	1993	1994	1995	1991–95
9. Increase and extend Airport Trust Fund aviation excise taxes (5 years)	12/1/90	1,351	2,335	2,520	2,727	2,975	11,908
10. Increase harbor maintenance excise tax	1/1/91	314	342	369	395	422	1,842
11. Extend telephone excise tax and modify collection period [6]	1/1/91	1,643	2,578	2,757	2,946	3,145	13,069
12. Revise treatment of loss deductions and salvage values for insurance companies.	1/1/90	204	83	90	98	106	581
13. Amortize insurance policy deferred acquisition expenses (DAC)	9/30/90	1,445	1,730	1,677	1,610	1,533	7,995
14. Adopt tax compliance provisions including certain provisions from H.R. 4308 and S. 2410.	3/20/90	42	47	78	63	68	298
15. Adopt retiree health provision with reversion excise increase and asset cushion requirement.		491	196	140	83	39	949
16. Increase by 2 percentage points the interest rate on corporate tax underpayments over $100,000 following notice from IRS.	1/1/91	1,559	96	79	46	46	1,826
17. Certain corporate business tax provisions:							
a. Expand and clarify reporting and allocation rules for certain asset acquisitions.	10/10/90	9	13	15	17	19	73
b. Require accrual of redemption premium for certain preferred stock	10/10/90	19	55	86	104	109	373
c. Expand application of CERT rules to subsidiary acquisitions	10/10/90	45	81	84	77	69	356
d. Require recognition of corporate-level gain in certain divisive corporate transactions (5-year limitation period).	10/10/90	9	25	38	49	60	181
e. Clarify treatment of debt exchanges	10/10/90	111	95	75	53	25	359
18. Extend IRS user fees (5 years) [6]	9/30/90	45	45	45	45	45	225
19. Extend Social Security (OASDHI) to State and local employees not participating in a public employee retirement system [7].	7/1/91	444	1,970	2,106	2,253	2,414	9,187
20. Extend FUTA 0.2% surtax (5 years)	1/1/91	787	1,106	1,137	1,167	1,199	5,396
21. Adopt payroll tax deposit stabilization		950	2,200	−3,150			
22. Extend Hazardous Substance Superfund taxes (4 years) [8]	1/1/92						
23. Increase Medicare (HI) wage cap to $125,000	1/1/91	1,848	5,709	6,058	6,439	6,827	26,881
24. Extend statute of limitations for collection from 6 years to 10 years	1/1/91	1	1	2	2	2	8

25. Increase penalty for intentional disregard of cash reporting requirement and adopt certain other modifications.	1/1/91						
26. Treat U.S. beneficiary as grantor of foreign trust indirectly funded by beneficiary.	10/27/90	2	23	46	91	135	297
Subtotals, deficit reduction provisions		20,204	35,044	32,402	37,444	39,507	164,601
B. Other provisions:							
1. Technical corrections							
2. Repeal obsolete provisions (deadwood)							
3. Revise Treasury Department study mandates							
4. Increase Joint Committee on Taxation refund review threshold	10/27/90						
5. Review impact of IRS Regulations on small business	11/26/90	([9])	([9])	([9])	([9])	([9])	([9])
6. Require pie charts in IRS tax form instruction booklets	1/1/91						
Subtotals, other provisions							
Subtotals: Revenue raising provisions		20,204	35,044	32,402	37,444	39,507	164,601
Grand totals		17,607	30,222	27,452	31,421	30,467	137,169

---

[1] All estimates assume full restoration of tax benefits for 1990.

[2] Increased EITC by number of children: In 1991: 1 child=16.7% credit, 11.93% phaseout; 2 children=17.3% credit, 12.36% phaseout. In 1992: 1 child=17.6% credit, 12.57% phaseout; 2 children=18.4% credit, 13.14% phaseout. In 1993: 1 child=18.5% credit, 13.21% phaseout; 2 children=19.5% credit, 13.93% phaseout. In 1994 and thereafter: 1 child=23% credit, 16.43% phaseout; 2 children=25% credit, 17.86% phaseout. Estimate incorporates the Treasury proposal to enhance compliance with EITC eligibility rules.

[3] 6% credit rate; 4.29% phaseout rate; phaseout income levels are the same as EITC.

[4] 5% credit rate; 3.57% phaseout rate; phaseout income levels are the same as EITC.

[5] Railroads will pay 50% of increase in rates. 50% of motor fuels tax increase dedicated to deficit reduction; remainder dedicated to Highway trust fund (20% of this portion to be allocated to mass transit account).

[6] Modification of collection period effective after 12/31/90.

[7] Estimates provided by the Congressional Budget Office (CBO).

[8] The estimate is presented relative to the CBO baseline which assumes automatic extension of provisions in present law when revenues are dedicated to specific trust funds and when the provision is scheduled to expire within the current budget period.

[9] Negligible amount.

Notes: Details may not add to totals due to rounding. Interaction between or among items has not been taken into account for the purpose of this table. In "Effective" column: D/o/E=Date of enactment; D/o/E+30=30 days after date of enactment.

TABLE 23.—DISTRIBUTIONAL EFFECTS OF THE MAJOR REVENUE AND ENTITLEMENT PROVISIONS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

Families by income group [1]	Average dollar effect [2]	Average after-tax income before proposal	Dollar effect as a percent of after-tax income
Lowest quintile [3]	111	7,316	1.5
Second quintile	−75	16,917	−0.4
Middle quintile	−219	25,896	−0.8
Fourth quintile	−290	36,481	−0.8
81 to 90 percent	−408	50,328	−0.8
91 to 95 percent	−562	63,950	−0.9
96 to 99 percent	−943	97,105	−1.0
Top 1 percent	−9,241	428,044	−2.2
All Families [4]	−298	33,401	−0.9
Fifth quintile	−988	81,934	−1.2
Top 10 percent	−1,541	112,042	−1.4

[1] Ranked by size of adjusted pre-tax family income. Family income is the sum of wages, salaries, and self-employment income; rents, interest, dividends, and realized capital gains; and all cash transfer payments. For purposes of ranking, income for each family is divided by the 1991 poverty threshold for a family of that size. Quintiles contain equal numbers of persons.

[2] The average dollar change in income is the sum of the average tax increase (or decrease) plus the average entitlement decrease (or increase) per family. A minus sign denotes a decrease in income (a tax increase or entitlement decrease). The change in taxes includes combined effects of federal individual and corporate income taxes, payroll taxes, and excise taxes. Excise taxes are assigned to consumers. The corporate income tax is assigned half to labor income and half to capital income.

[3] Excludes families with zero or negative incomes.

[4] Includes families with zero or negative incomes not shown separately.

Note: The table shows the 1-year effect at 1991 income levels of the following tax and entitlement provisions:

Revenue-losing provisions: An increase in the earned income tax credit (EITC), including supplemental young child credit; Child health insurance credit; Child care grants; Child health provisions; Energy and business tax incentives.

Revenue-raising provisions: A reduction of itemized deductions equal to 3 percent of income in excess of $100,000 (20 percent floor on itemized deductions); An individual income tax rate structure of 15/28/31 percent (28 percent maximum rate on capital gains, 24 percent alternative minimum tax); Phase-out of personal exemption for high-income taxpayers; An 8 cent increase in the tobacco tax; Increases in excises taxes on distilled spirits, beer, and wine; A 10 percent luxury excise tax; A 5-cent-per-gallon increase in motor fuels taxes; An increase in the gas guzzler tax; Amortization of insurance policy deferred acquisition expenses (DAC) and other insurance provisions; Tax increases for corporations and businesses; Increases in Airport and Airway Trust Fund aviation taxes; An Increase in the cap on wages subject to the Medicare Hospital Insurance (HI) payroll tax to $125,000; Extend social security (OASDI) coverage to certain State and local employees; Extension of the 0.2 percent FUTA surtax; Extension of the telephone excise tax.

Entitlement, mandatory spending, and user fee provisions: Increases in Medicare premium, deductible and coinsurance ($10.1 billion over 5 years), with premium relief for the near-poor elderly; Postal service reform; Bank insurance fund assessment; Other user fees.

Source: Congressional Budget Office Simulation Models.

TABLE 24.—THE ADMINISTRATION'S POLICY PROPOSALS AS ESTIMATED BY CBO

[By fiscal year, billions of dollars]

	1992	1993	1994	1995	1996
CBO deficit estimate assuming discretionary caps	294	221	169	69	66
Policy changes:					
Discretionary	5	1	4	1	−12
Pay-as-you-go:					
Spending	−6	−6	−4	−5	−6
Revenues [1]	−3	4	6	7	9
Subtotal	−9	−2	2	1	3
Other mandatory	−1	0	−2	0	−1
Total	−4	0	4	2	−10
President's budget as estimated by CBO	290	221	173	71	56

[1] Revenue increases are shown with a negative sign because they reduce the deficit.

Note: The estimates include Social Security and the Postal Service, which are off-budget.

Source: Congressional Budget Office.

TABLE 25.—THE ADMINISTRATION'S PAY-AS-YOU-GO PROPOSALS

[By fiscal year, in billions of dollars]

	1992	1993	1994	1995	1996
Spending:					
PMA debt restructuring	0	−0.4	−0.4	−0.4	−0.4
Guaranteed student loans	−1.0	(1)	(1)	(1)	0
Medicare	−2.6	−3.8	−4.8	−5.6	−6.0
Veterans benefits	−1.3	−.6	−.7	−.7	−.6
Military retirement accruals	0	0	3.1	2.8	2.5
Other	−1.0	−1.1	−1.5	−1.6	−1.8
Subtotal	−5.9	−6.0	−4.3	−5.5	−6.3
Revenues: [2]					
Extend expiring income tax provisions	1.3	1.9	1.8	2.0	2.2
Exclude 30 percent of capital gains [3]	−3.7	3.2	4.4	4.1	3.4
Establish family savings accounts	.4	.6	1.0	1.4	1.8
Extend Medicare taxes to all state and local government employees	−1.1	−1.5	−1.5	−1.5	−1.5
Other	.2	.3	.4	.6	3.3
Subtotal	−3.0	4.4	6.0	6.6	9.2
CBO estimate of pay-as-you-go	−8.9	−1.5	1.7	1.1	2.9
Administration estimate of pay-as-you-go	−9.0	−9.8	−8.1	−9.9	−6.5

[1] Less than $50 million.

[2] Revenue increases are shown with a negative sign because they reduce the deficit.

[3] Increases revenues by $0.8 billion in 1991.

Sources: Congressional Budget Office; Joint Committee on Taxation; and Office of Management and Budget.

TABLE 26.—SUMMARY OF CBO ESTIMATES OF PROPOSED ADMINISTRATION POLICY CHANGES IN ENTITLEMENT PROGRAMS UNDER THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

[By fiscal year, in millions of dollars]

	1992	1993	1994	1995	1996	Total 1992–96
Medicare:						
Clinical labs	−530	−905	−1,035	−1,180	−1,345	−4,995
DME	−55	−100	−120	−140	−155	−570
High income beneficiary premium increase	−27	−121	−202	−291	−409	−1,050
Hospitals and outpatients	−1,640	−2,205	−2,865	−3,335	−3,505	−13,550
Physicians	−140	−350	−440	−500	−580	−2,020
Other	−346	−216	−207	−187	−77	−1,033
Subtotal—Medicare	−2,738	−3,897	−4,879	−5,633	−6,071	−23,218
Social Security and railroad retirement	200	167	79	66	67	579
Child support enforcement	−109	−136	−152	−177	−203	−777
SSI	−97	−162	−239	−250	−261	−1,009
Foster care	−188	−285	−345	−407	−476	−1,701
Trade adjustment assistance	−115	−206	−215	−208	−200	−944
Total	−3,047	−4,519	−5,751	−6,609	−7,144	−27,070

Source: Congressional Budget Office.

TABLE 27.—CBO ESTIMATES OF ADMINISTRATION LEGISLATIVE PROPOSALS FOR PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS BY PROVISION

[By fiscal years, in millions]

	1992	1993	1994	1995	1996	Total 1992–96
MEDICARE						
PPS update	−400	−545	−905	−1,045	−855	−3,750
Indirect medical education	−1,040	−1,380	−1,640	−1,940	−2,260	−8,260
Direct medical education	−120	−140	−145	−150	−155	−710
DRG payment window	−30	−40	−50	−50	−60	−230
Eliminate return on equity (ROE) payments to skilled nursing facilities (SNFs)	−45	−60	−60	−65	−70	−300
Update for physician fees	0	0	0	0	0	0
Medicare volume performance standard for 1991	0	−110	−180	−195	−240	−725
Anesthesiology services	−95	−155	−175	−195	−220	−840
Payments for assistants-at-surgery	−35	−55	−60	−65	−75	−290
Eliminate payments for specimen collections	−10	−20	−20	−25	−25	−100
Payments for covered drugs	−10	−15	−15	−20	−20	−80
Payments for radiology and other diagnostic tests	0	−10	−15	−20	−20	−65
Clinical laboratory services [1]	−510	−855	−970	−1,105	−1,260	−4,700
Reduce update	−20	−50	−65	−75	−85	−295
Durable medical equipment	−45	−85	−105	−120	−135	−490
Enteral/parenteral fee schedule	−10	−15	−15	−20	−20	−80
Hospital outpatient department services	−50	−100	−125	−150	−175	−600
Payments to providers for physical and respiratory therapy services	−10	−10	−15	−15	−20	−70
Home health cost limits	−90	−110	−120	−130	−145	−595
Uniform Medicare secondary payer employee size threshold:						
Part A	−55	−65	−75	−90	−105	−390
Part B	−25	−25	−35	−40	−45	−170
Total	−80	−90	−110	−130	−150	−560
Part B premium	−27	−121	−202	−291	−409	−1,050
State certification user fee:						
Part A	−131	−140	−141	−141	−141	−694
Part B	−20	−21	−21	−21	−21	−104
Total	−151	−161	−162	−162	−162	−798
Coordinated care initiatives:						
Part A	25	75	90	105	120	415
Part B	15	155	185	230	370	955
Total	40	230	275	335	490	1,370
Effect of Medicare proposals on HI premiums [2]	0	0	0	0	0	0
Subtotal	−2,738	−3,897	−4,879	−5,633	−6,071	−23,218
SOCIAL SECURITY AND RAILROAD RETIREMENT						
Social Security retirement test	140	105	15	0	0	260
Social Security benefits for railroad retirement dependents	60	62	64	66	67	319
Subtotal	200	167	79	66	67	579

TABLE 27.—CBO ESTIMATES OF ADMINISTRATION LEGISLATIVE PROPOSALS FOR PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS BY PROVISION—Continued

[By fiscal years, in millions]

	1992	1993	1994	1995	1996	Total 1992–96
CHILD SUPPORT ENFORCEMENT						
Incentive payments [3]	−54	−66	−77	−92	−103	−392
Application fees	−55	−70	−75	−85	−100	−385
Subtotal	−109	−136	−152	−177	−203	−777
SUPPLEMENTAL SECURITY INCOME						
Fee for administration of State supplementation	−65	−140	−220	−230	−240	−895
Collection of SSI overpayments	−32	−22	−19	−20	−21	−114
Subtotal	−97	−162	−239	−250	−261	−1,009
CHILD WELFARE SERVICES AND FOSTER CARE						
Prohibition on reimbursement for preplacement activities	−188	−285	−345	−407	−476	−1,701
TRADE ADJUSTMENT ASSISTANCE						
Terminate the TAA program	−115	−206	−215	−208	−200	−944
Total	−3,047	−4,519	−5,751	−6,609	−7,144	−27,070

---

[1] Includes effect on Medicaid.

[2] CBO did not include an estimate of the effect of Medicare proposals on HI premiums in its reestimate of the President's budget.

[3] This proposal is not fully specified at this time. Thus, CBO has used the Administration's estimate, which may change when details become available.

Source: Congressional Budget Office.

TABLE 28.—ESTIMATED BUDGET EFFECTS OF REVENUE PROVISIONS IN THE PRESIDENT'S FISCAL YEAR 1992 BUDGET PROPOSAL—FISCAL YEARS 1991–96

[Billions of dollars]

Provisions	1991	1992	1993	1994	1995	1996	1991–96
A. Income tax provisions:							
1. Capital gains tax rate reduction for individuals	0.8	3.7	−3.2	−4.4	−4.1	−3.4	−10.6
2. Establish family savings accounts		−0.4	−0.6	−1.0	−1.4	−1.8	−5.2
3. Waive penalty tax for early withdrawals from IRAs for first-time home buyers		−0.2	−0.1	−0.1	−0.1	−0.1	−0.6
4. Restore and double deduction for adoption of special needs children			(1)	(1)	(1)	(1)	(1)
5. Establish enterprise zone tax incentives	(2)	(2)	(2)	(2)	(2)	(2)	(2)
6. Extend tax deadlines for Desert Shield participants (enacted in H.R. 4)							
B. Expiring tax provisions:							
1. Permanent extension of R&E credit		−0.5	−1.0	−1.3	−1.6	−1.8	−6.2
2. Extend R&E allocation rules (1 year)		−0.4	−0.3				−0.7
3. Extend low-income housing tax credit (1 year)		−0.1	−0.3	−0.4	−0.4	−0.4	−1.5
4. Extend targeted jobs tax credit (1 year)		−0.1	−0.1	−0.1	(1)	(1)	−0.4
5. Extend business energy tax credits (1 year)		(1)	(1)				(1)
6. Extend health insurance deduction for self-employed (1 year)		−0.8	−0.1				−0.4
C. Compliance provisions:							
1. Increase IRS enforcement funding [3]							
2. Improve retail compliance with alcohol special occupational taxes [4]		(5)	(5)	(5)	(5)	(5)	0.1
D. Other tax provisions:							
1. Extend Highway Trust Fund excise taxes (1 year) [4, 6]						−2.8	−2.8
2. Extend Medicare (HI) coverage to all State and local employees [3, 4]		1.1	1.5	1.5	1.5	1.5	7.2
3. Extend railroad unemployment insurance (UI) reimbursable status [3, 4]	(1)	(5)	(5)	(5)	(1)	(1)	(5)

TABLE 28.—ESTIMATED BUDGET EFFECTS OF REVENUE PROVISIONS IN THE PRESIDENT'S FISCAL YEAR 1992 BUDGET PROPOSAL—FISCAL YEARS 1991–96—Continued

[Billions of dollars]

Provisions	1991	1992	1993	1994	1995	1996	1991–96
E. Certain user fees:							
1. Extend abandoned mine reclamation fees [3]						0.8	0.8
2. Increase HUD interstate land sales fee [2]	(7)	(7)	(7)	(7)	(7)	(7)	(5)
Grand total [8]	0.8	2.8	−4.2	−5.8	−6.1	−8.5	−20.8

---

[1] Loss of $50 million or less.

[2] Uncertainty about the size, location, and economic characteristics of enterprise zones to be designated makes the proposal difficult to estimate at this time.

[3] Estimate for this provision provided by the Congressional Budget Office (CBO).

[4] Net of income tax offsets.

[5] Gain of $50 million or less.

[6] Extend existing Trust Fund taxes from October 1, 1995, through September 30, 1996, but at 9 cents per gallon for gasoline and 15 cents per gallon for diesel fuel for the 1-year extension period. Estimate is relative to the CBO baseline, which assumes extension of these motor fuels taxes at 11.5 cents per gallon for gasoline and 17.5 cents per gallon for diesel fuel (the Highway Trust Fund financing rates).

[7] Gain of less than $1 million.

[8] Not including the enterprise zones proposal (A. 5.).

Source: Joint Committee on Taxation; Congressional Budget Office (Items C.1., D.2., D.3., E.1., and E.2.).

TABLE 29.—DISTRIBUTIONAL EFFECTS OF THE MAJOR REVENUE AND ENTITLEMENT PROVISIONS OF THE PRESIDENT'S 1992 BUDGET PROPOSALS

Families by income group [1]	Average dollar effect [2]	Average after-tax income before proposal	Dollar effect as a percent of after-tax income
Lowest quintile [3]	−13	7,435	−0.2
Second quintile	−19	16,957	−0.1
Middle quintile	−20	25,672	−0.1
Fourth quintile	−3	37,096	−0.0
81 to 90 percent	56	49,510	0.1
91 to 95 percent	139	62,629	0.2
96 to 99 percent	456	96,551	0.5
Top 1 percent	5,497	477,783	1.2
All families	74	33,771	0.2
Fifth quintile	412	82,447	0.5
Top 10 percent	753	114,006	0.7

---

[1] Ranked by size of adjusted pretax family income. Family income is the sum of wages, salaries, and self-employment income; rents, interest, dividends, and realized capital gains; and all cash transfer payments. For purposes of ranking, income for each family is divided by the 1991 poverty threshold for a family of that size. Quntiles contain equal numbers of persons.

[2] The average dollar change in income is the sum of the average tax increase (or increase) plus the average entitlement decrease (or decrease) per family. A minus sign denotes a decrease in income (a tax increase or entitlement decrease). The change in taxes includes combined effects of Federal individual and corporate income taxes, payroll taxes, and excise taxes. Excise taxes are assigned to consumers. The corporate income tax is assigned half to labor income and half to capital income.

[3] Excludes families with zero or negative incomes.

Note: The table shows the 1-year effect at 1992 income levels of the following tax and entitlement provisions:

Revenue provisions: Capital gains; hospital insurance coverage to State and local employees; extension of the research and experimentation credit family savings account.

Entitlement and mandatory program provisions: 20 percent coinsurance on clinical labs; elimination of trade adjustment assistance; no farm payments for wealthy farmers; increased premiums for high-income Medicare beneficiaries; user fees of $1.75 billion.

Source: Congressional Budget Office Simulation Models.

TABLE 30.—REVENUES, OUTLAYS, DEFICITS, AND DEBT HELD BY THE PUBLIC, FISCAL YEARS 1962–90

[In billions of dollars]

	Revenues	Outlays	Deficit (−) or Surplus				Debt held by the public
			On-Budget	Social Security	Postal Service	Total	
1962	99.7	106.8	−5.9	−1.3	0	−7.1	248.0
1963	106.6	111.3	−4.0	−.8	0	−4.8	254.0
1964	112.6	118.5	−6.5	.6	0	−5.9	256.8
1965	116.8	118.2	−1.6	.2	0	−1.4	260.8
1966	130.8	134.5	−3.1	−.6	0	−3.7	263.7
1967	148.8	157.5	−12.6	4.0	0	−8.6	266.6
1968	153.0	178.1	−27.7	2.6	0	−25.2	289.5
1969	186.9	183.6	−0.5	3.7	0	−3.2	278.1
1970	192.8	195.6	−8.7	5.9	0	−2.8	283.2
1971	187.1	210.2	−26.1	3.0	0	−23.0	303.0
1972	207.3	230.7	−26.4	3.1	0	−23.4	322.4
1973	230.8	245.7	−15.4	.5	0	−14.9	340.9
1974	263.2	269.4	−8.0	1.8	0	−6.1	343.7
1975	279.1	332.3	−55.3	2.0	0	−53.2	394.7
1976	298.1	371.8	−70.5	−3.2	0	−73.7	477.4
1977	355.6	409.2	−49.7	−3.9	0	−53.6	549.1
1978	399.6	458.7	−54.9	−4.3	0	−59.2	607.1
1979	463.3	503.5	−38.2	−2.0	0	−40.2	639.8
1980	517.1	590.9	−72.7	−1.1	0	−73.8	709.3
1981	599.3	678.2	−73.9	−5.0	0	−78.9	784.8
1982	617.8	745.7	−120.0	−7.9	0	−127.9	919.2
1983	600.6	808.3	−208.0	.2	0	−207.8	1,131.0
1984	666.5	851.8	−185.6	.3	0	−185.3	1,300.0
1985	734.1	946.3	−221.6	9.4	0	−212.3	1,499.4
1986	769.1	990.3	−237.9	16.7	0	−221.2	1,736.2
1987	854.1	1,003.8	−169.3	19.6	0	−149.7	1,888.1
1988	909.0	1,064.1	−193.9	38.8	0	−155.1	2,050.3
1989	990.7	1,144.1	−206.1	52.4	0	−153.4	2,190.7
1990	1,031.5	1,251.9	−277.0	58.2	−1.6	−220.4	2,410.4

Source: Congressional Budget Office.

TABLE 31.—REVENUES, OUTLAYS, DEFICITS, AND DEBT HELD BY THE PUBLIC, FISCAL YEARS 1962–90

[As a percentage of GNP]

	Revenues	Outlays	Deficit(—) or surplus				Debt held by the public
			On-budget	Social Security	Postal Service	Total	
1962	17.9	19.2	—1.1	—.2	0	—1.3	44.5
1963	18.1	18.9	—.7	—.1	0	—.8	43.2
1964	17.9	18.8	—1.0	.1	0	—.9	40.8
1965	17.4	17.6	—.2	(1)	0	—.2	38.8
1966	17.7	18.2	—.4	—.1	0	—.5	35.7
1967	18.7	19.8	—1.6	.5	0	—1.1	33.6
1968	18.0	21.0	—3.3	.3	0	—3.0	34.1
1969	20.1	19.8	—.1	.4	0	—.3	29.9
1970	19.5	19.8	—.9	.6	0	—.3	28.6
1971	17.7	19.9	—2.5	.3	0	—2.2	28.7
1972	18.0	20.0	—2.3	.3	0	—2.0	28.0
1973	18.0	19.2	—1.2	(1)	0	—1.2	26.6
1974	18.6	19.0	—.6	.1	0	—.4	24.3
1975	18.3	21.8	—3.6	.1	0	—3.5	25.9
1976	17.6	21.9	—4.2	—.2	0	—4.3	28.1
1977	18.4	21.2	—2.6	—.2	0	—2.8	28.4
1978	18.4	21.1	—2.5	—.2	0	—2.7	28.0
1979	18.9	20.6	—1.6	—.1	0	—1.6	26.1
1980	19.4	22.1	—2.7	(1)	0	—2.8	26.6
1981	20.1	22.7	—2.5	—.2	0	—2.6	26.3
1982	19.7	23.8	—3.8	—.3	0	—4.1	29.3
1983	18.1	24.3	—6.3	(1)	0	—6.3	34.0
1984	18.1	23.1	—5.0	(1)	0	—5.0	35.3
1985	18.6	23.9	—5.6	.2	0	—5.4	37.9
1986	18.4	23.7	—5.7	.4	0	—5.3	41.5
1987	19.3	22.7	—3.8	.4	0	—3.4	42.7
1988	19.0	22.3	—4.1	.8	0	—3.2	42.9
1989	19.3	22.3	—4.0	1.0	(1)	3.0	42.7
1990	19.1	23.2	—5.1	1.1	(1)	—4.1	44.6

[1] Less than 0.05 percent.

Source: Congressional Budget Office.

TABLE 32.—REVENUES, BY MAJOR SOURCE, FISCAL YEARS 1962–90

[In billions of dollars]

Fiscal year	Individual income taxes	Corporate income taxes	Social insurance taxes	Excise taxes	Estate and gift taxes	Customs duties	Miscellaneous receipts	Total revenues
1962	45.6	20.5	17.0	12.5	2.0	1.1	0.8	99.7
1963	47.6	21.6	19.8	13.2	2.2	1.2	1.0	106.6
1964	48.7	23.5	22.0	13.7	2.4	1.3	1.1	112.6
1965	48.8	25.5	22.2	14.6	2.7	1.4	1.6	116.8
1966	55.4	30.1	25.5	13.1	3.1	1.8	1.9	130.8
1967	61.5	34.0	32.6	13.7	3.0	1.9	2.1	148.8
1968	68.7	28.7	33.9	14.1	3.1	2.0	2.5	153.0
1969	87.2	36.7	39.0	15.2	3.5	2.3	2.9	186.9
1970	90.4	32.8	44.4	15.7	3.6	2.4	3.4	192.8
1971	86.2	26.8	47.3	16.6	3.7	2.6	3.9	187.1
1972	94.7	32.2	52.6	15.5	5.4	3.3	3.6	207.3
1973	103.2	36.2	63.1	16.3	4.9	3.2	3.9	230.8
1974	119.0	38.6	75.1	16.8	5.0	3.3	5.4	263.2
1975	122.4	40.6	84.5	16.6	4.6	3.7	6.7	279.1
1976	131.6	41.4	90.8	17.0	5.2	4.1	8.0	298.1
1977	157.6	54.9	106.5	17.5	7.3	5.2	6.5	355.6
1978	181.0	60.0	121.0	18.4	5.3	6.6	7.4	399.6
1979	217.8	65.7	138.9	18.7	5.4	7.4	9.3	463.3
1980	244.1	64.6	157.8	24.3	6.4	7.2	12.7	517.1
1981	285.9	61.1	182.7	40.8	6.8	8.1	13.8	599.3
1982	297.7	49.2	201.5	36.3	8.0	8.9	16.2	617.8
1983	288.9	37.0	209.0	35.3	6.1	8.7	15.6	600.6
1984	298.4	56.9	239.4	37.4	6.0	11.4	17.0	666.5
1985	334.5	61.3	265.2	36.0	6.4	12.1	18.5	734.1
1986	349.0	63.1	283.9	32.9	7.0	13.3	19.9	769.1
1987	392.6	83.9	303.3	32.5	7.5	15.1	19.3	854.1
1988	401.2	94.5	334.3	35.2	7.6	16.2	19.9	909.0
1989	445.7	103.3	359.4	34.4	8.7	16.3	22.8	990.7
1990	466.9	93.5	380.0	35.3	11.5	16.7	27.5	1,031.5

Source: Congressional Budget Office.

TABLE 33.—REVENUES, BY MAJOR SOURCE, FISCAL YEARS 1962–90

[As a percentage of GNP]

Fiscal year	Individual income taxes	Corporate income taxes	Social insurance taxes	Excise taxes	Estate and gift taxes	Customs duties	Miscellaneous receipts	Total revenues
1962	8.2	3.7	3.1	2.2	0.4	0.2	0.2	17.9
1963	8.1	3.7	3.4	2.2	.4	.2	.2	18.1
1964	7.7	3.7	3.5	2.2	.4	.2	.2	17.9
1965	7.3	3.8	3.3	2.2	.4	.2	.2	17.4
1966	7.5	4.1	3.5	1.8	.4	.2	.3	17.7
1967	7.7	4.3	4.1	1.7	.4	.2	.3	18.7
1968	8.1	3.4	4.0	1.7	.4	.2	.3	18.0
1969	9.4	3.9	4.2	1.6	.4	.2	.3	20.1
1970	9.1	3.3	4.5	1.6	.4	.2	.3	19.5
1971	8.2	2.5	4.5	1.6	.4	.2	.4	17.7
1972	8.2	2.8	4.6	1.3	.5	.3	.3	18.0
1973	8.1	2.8	4.9	1.3	.4	.2	.3	18.0
1974	8.4	2.7	5.3	1.2	.4	.2	.4	18.6
1975	8.0	2.7	5.6	1.1	.3	.2	.4	18.3
1976	7.7	2.4	5.3	1.0	.3	.2	.5	17.6
1977	8.2	2.8	5.5	.9	.4	.3	.3	18.4
1978	8.3	2.8	5.6	.8	.2	.3	.3	18.4
1979	8.9	2.7	5.7	.8	.2	.3	.4	18.9
1980	9.1	2.4	5.9	.9	.2	.3	.5	19.4
1981	9.6	2.0	6.1	1.4	.2	.3	.5	20.1
1982	9.5	1.6	6.4	1.2	.3	.3	.5	19.7
1983	8.7	1.1	6.3	1.1	.2	.3	.5	18.1
1984	8.1	1.5	6.5	1.0	.2	.3	.5	18.1
1985	8.5	1.6	6.7	.9	.2	.3	.5	18.6
1986	8.3	1.5	6.8	.8	.2	.3	.5	18.4
1987	8.9	1.9	6.9	.7	.2	.3	.4	19.3
1988	8.4	2.0	7.0	.7	.2	.3	.4	19.0
1989	8.7	2.0	7.0	.7	.2	.3	.4	19.3
1990	8.6	1.7	7.0	.7	.2	.3	.5	19.1

Source: Congressional Budget Office.

TABLE 34.—OUTLAYS FOR MAJOR SPENDING CATEGORIES, FISCAL YEARS 1962–90

[In billions of dollars]

Fiscal year	National defense	Entitlements and other mandatory spending	Nondefense discretionary spending	Net interest	Offsetting receipts	Total outlays
1962	52.3	30.8	23.8	6.9	−7.1	106.8
1963	53.4	33.3	25.0	7.7	−8.1	111.3
1964	54.8	34.5	28.9	8.2	−7.8	118.5
1965	50.6	34.8	32.3	8.6	−8.0	118.2
1966	58.1	37.5	38.1	9.4	−8.5	134.5
1967	71.4	45.3	40.8	10.3	−10.3	157.5
1968	81.9	52.3	43.6	11.1	−10.8	178.1
1969	82.5	58.7	40.8	12.7	−11.1	183.6
1970	81.7	66.1	45.1	14.4	−11.6	195.6
1971	78.9	80.6	50.1	14.8	−14.2	210.2
1972	79.2	94.2	56.0	15.5	−14.2	230.7
1973	76.7	110.4	59.5	17.3	−18.1	245.7
1974	79.3	125.0	64.9	21.4	−21.3	269.4
1975	86.5	158.0	83.0	23.2	−18.5	332.3
1976	89.6	184.3	91.0	26.7	−19.8	371.8
1977	97.2	198.5	105.2	29.9	−21.6	409.2
1978	104.5	220.9	120.9	35.4	−23.0	458.7
1979	116.3	240.8	129.8	42.6	−26.1	503.5
1980	134.0	282.3	152.4	52.5	−30.4	590.9
1981	157.5	326.3	164.9	68.7	−39.3	678.2
1982	185.3	358.8	153.8	85.0	−37.2	745.7
1983	209.9	400.9	153.8	89.8	−46.1	808.3
1984	227.4	397.2	161.5	111.1	−45.3	851.8
1985	252.7	442.6	169.6	129.4	−48.0	946.3
1986	273.4	458.0	170.0	136.0	−47.0	990.3
1987	282.0	474.1	163.4	138.6	−54.2	1,003.8
1988	290.4	504.7	175.2	151.7	−58.0	1,064.1
1989	303.6	546.6	189.4	169.1	−64.6	1,144.1
1990	299.3	620.4	205.6	183.8	−57.2	1,251.9

Source: Congressional Budget Office.

TABLE 35.—OUTLAYS FOR MAJOR SPENDING CATEGORIES, FISCAL YEARS 1962–90

[As a percentage of GNP]

Fiscal year	National Defense	Entitlements and other mandatory spending	Nondefense discretionary spending	Net interest	Offsetting receipts	Total outlays
1962	9.4	5.5	4.3	1.2	−1.3	19.2
1963	9.1	5.7	4.3	1.3	−1.4	18.9
1964	8.7	5.5	4.6	1.3	−1.2	18.8
1965	7.5	5.2	4.8	1.3	−1.2	17.6
1966	7.9	5.1	5.1	1.3	−1.2	18.2
1967	9.0	5.7	5.1	1.3	−1.3	19.8
1968	9.6	6.2	5.1	1.3	−1.3	21.0
1969	8.9	6.3	4.4	1.4	−1.2	19.8
1970	8.2	6.7	4.6	1.5	−1.2	19.8
1971	7.5	7.6	4.7	1.4	−1.3	19.9
1972	6.9	8.2	4.9	1.3	−1.2	20.0
1973	6.0	8.6	4.6	1.4	−1.4	19.2
1974	5.6	8.8	4.6	1.5	−1.5	19.0
1975	5.7	10.4	5.5	1.5	−1.2	21.8
1976	5.3	10.8	5.4	1.6	−1.2	21.9
1977	5.0	10.3	5.4	1.5	−1.1	21.2
1978	4.8	10.2	5.6	1.6	−1.1	21.1
1979	4.8	9.8	5.3	1.7	−1.1	20.6
1980	5.0	10.6	5.7	2.0	−1.1	22.1
1981	5.3	10.9	5.5	2.3	−1.3	22.7
1982	5.9	11.4	4.9	2.7	−1.2	23.8
1983	6.3	12.1	4.6	2.7	−1.4	24.3
1984	6.2	10.8	4.4	3.0	−1.2	23.1
1985	6.4	11.2	4.3	3.3	−1.2	23.9
1986	6.5	11.0	4.1	3.3	−1.1	23.7
1987	6.4	10.7	3.7	3.1	−1.2	22.7
1988	6.1	10.6	3.7	3.2	−1.2	22.3
1989	5.9	10.7	3.7	3.3	−1.3	22.3
1990	5.5	11.5	3.8	3.4	−1.1	23.2

Source: Congressional Budget Office.

TABLE 36.—FEDERAL FINANCES AND THE FEDERAL DEBT, 1955–90

[Dollar amounts in billions]

	Total deficit		Federal debt, end of year					
			Gross		Held by Government accounts		Held by the public	
	Amount	Percent of GNP	Amount	Percent of GNP	Amount	Percent of GNP	Amount	Percent of GNP
1955	−3.0	−.8	274.3	71.0	47.8	12.4	226.6	58.6
1956	3.9	.9	272.7	65.2	50.5	12.1	222.2	53.1
1957	3.4	.8	272.2	61.8	52.9	12.0	219.3	49.8
1958	−2.8	−.6	279.7	62.1	53.3	11.8	226.3	50.3
1959	−12.8	−2.7	287.5	59.7	52.8	11.0	234.7	48.7
1960	.3	.1	290.5	57.3	53.7	10.6	236.8	46.7
1961	−3.3	−.6	292.6	56.5	54.3	10.5	238.4	46.0
1962	−7.1	−1.3	302.9	54.3	54.9	9.8	248.0	44.5
1963	−4.8	−.8	310.3	52.8	56.3	9.6	254.0	43.2
1964	−5.9	−.9	316.1	50.2	59.2	9.4	256.8	40.8
1965	−1.4	−.2	322.3	47.9	61.5	9.1	260.8	38.8
1966	−3.7	−.5	328.5	44.5	64.8	8.8	263.7	35.7
1967	−8.6	−1.1	340.4	42.8	73.8	9.3	266.6	33.6
1968	−25.2	−3.0	368.7	43.4	79.1	9.3	289.5	34.1
1969	3.2	.3	365.8	39.4	87.7	9.4	278.1	29.9
1970	−2.8	−.3	380.9	38.5	97.7	9.9	283.2	28.6
1971	−23.0	−2.2	408.2	38.7	105.1	10.0	303.0	28.7
1972	−23.4	−2.0	435.9	37.8	113.6	9.8	322.4	28.0
1973	−14.9	−1.2	466.3	36.4	125.4	9.8	340.9	26.6
1974	−6.1	−.4	483.9	34.2	140.2	9.9	343.7	24.3
1975	−53.2	−3.5	541.9	35.6	147.2	9.7	394.7	25.9
1976	−73.7	−4.3	629.0	37.0	151.6	8.9	477.4	28.1
TQ			643.6	35.9	148.1	8.2	495.5	27.6
1977	−53.6	−2.8	706.4	36.5	157.3	8.1	549.1	28.4
1978	−59.2	−2.7	776.6	35.8	169.5	7.8	607.1	28.0
1979	−40.2	−1.6	828.9	33.9	189.2	7.7	639.8	26.1
1980	−73.8	−2.8	908.5	34.0	199.2	7.5	709.3	26.6
1981	−78.9	−2.6	994.3	33.3	209.5	7.0	784.8	26.3
1982	−127.9	−4.1	1,136.8	36.2	217.6	6.9	919.2	29.3
1983	−207.8	−6.3	1,371.2	41.3	240.1	7.2	1,131.0	34.0
1984	−185.3	−5.0	1,564.1	42.4	264.2	7.2	1,300.0	35.3
1985	−212.3	−5.4	1,817.0	46.0	317.6	8.0	1,499.4	37.9
1986	−221.2	−5.3	2,120.1	50.6	383.9	9.2	1,736.2	41.6
1987	−149.7	−3.4	2,345.6	52.9	457.4	10.3	1,888.1	42.6
1988	−155.1	−3.2	2,600.8	54.3	550.5	11.5	2,050.2	42.8
1989	−153.9	−3.0	2,866.2	55.6	676.9	13.1	2,189.3	42.5
1990	−220.4	−4.1	3,206.3	58.7	755.9	13.8	2410.4	44.1

[1] 0.05 percent or less.

Note.—Excludes transition quarter. Estimates assume Administration's budget.

Source: Historical Tables, tables 1.1 and 7.1. Budget of the United States Government, Fiscal Year 1992.

TABLE 37.—CBO PROJECTIONS OF INTEREST COSTS AND FEDERAL DEBT

[By fiscal year, in billions of dollars]

	1990	1991	1992	1993	1994	1995	1996
Net interest outlays:							
Interest on public debt (gross interest) [1]	265	292	312	337	355	367	377
Interest received by trust funds:							
Social Security	−16	−21	−26	−31	−37	−45	−53
Other trust funds [2]	−46	−52	−54	−57	−61	−65	−68
Subtotal	−62	−73	−79	−88	−98	−109	−121
Other interest [3]	−19	−21	−26	−30	−30	−28	−23
Total	184	198	207	219	227	230	233
Federal debt, end of year:							
Gross Federal debt	3,206	3,606	4,018	4,383	4,716	4,964	5,227
Debt held by Government accounts:							
Social Security	215	278	348	430	526	638	767
Other Government accounts [2]	581	635	697	769	844	921	995
Subtotal	796	913	1,045	1,198	1,370	1,558	1,762
Debt held by the public	2,410	2,693	2,973	3,185	3,346	3,405	3,465
Debt subject to limit [4]	3,161	3,565	3,980	4,348	4,682	4,931	5,195
Federal debt as a percentage of GNP:							
Debt held by the public	44.6	47.9	49.5	49.7	49.1	47.0	45.0

---

[1] Excludes interest costs of debt issued by agencies other than the Treasury (primarily deposit insurance agencies).

[2] Principally civil service retirement, military retirement, Medicare, Unemployment Insurance, and the Highway and the Airport and Airway trust funds.

[3] Primarily interest on loans to the public and to the Resolution Trust Corporation.

[4] Differs from the gross federal debt primarily because most debt issued by agencies other than the Treasury (currently about $33 billion) is excluded from the debt limit.

Note: Projections of interest and debt assume compliance with the discretionary spending caps in the Budget Enforcement Act.

Source: Congressional Budget Office.

TABLE 38.—STATUTORY DEBT LIMIT AND DEBT SUBJECT TO LIMIT, 1977–90

[In billions of dollars]

End of fiscal year	Statutory debt limit	Debt subject to limit
1977	700.0	700.0
1978	798.0	772.7
1979	879.0	827.6
1980	925.0	908.7
1981	1,079.8	998.8
1982	1,290.2	1,142.9
1983	1,389.0	1,378.0
1984	1,573.0	1,573.0
1985	1,823.8	1,823.8
1986	2,111.0	2,111.0
1987	2,800.0	2,336.0
1988	2,800.0	2,586.9
1989	2,870.0	2,829.8
1990	3,195.0	3,161.2

Source: OMB Historical Tables, tables 7.2, 7.3.

TABLE 39.—STATUTORY LIMITS ON FEDERAL DEBT: 1981—CURRENT

[Dollars in billions]

Date and act	History of legislation	Amount of limit
December 19, 1980, 94 Stat. 3261	Increased the total debt limit to $935.1 billion (composed of $400.0 billion of permanent ceiling, $535.1 billion of temporary ceiling).	$935.1
February 7, 1981, 95 Stat. 4	Increased the temporary portion of the debt limit to $585.0 billion (to a total debt ceiling of $985.0 billion) through September 30, 1980.	985.0
September 30, 1981, 95 Stat. 955	Increased the temporary portion of the debt limit to $599.8 billion for one day—September 30, 1981	999.8
September 30, 1981, 95 Stat. 956	Increased the temporary portion of the debt limit to $679.8 billion through September 30, 1982	1,079.8
June 28, 1982, 96 Stat. 130	Increased the temporary portion of the debt limit to $743.1 billion through September 30, 1982	1,143.1
September 30, 1982, 96 Stat. 1156	Increased the temporary portion of the debt limit to $890.2 billion through September 30, 1983	1,290.2
May 26, 1983, 97 Stat. 196	Eliminated the distinction between permanent and temporary limit with the enactment of a single permanent limit. Raised the debt limit to $1,389.0 billion.	1,389.0
November 21, 1983, 97 Stat. 1012	Increased the debt limit to $1,490.0 billion	1,490.0
May 25, 1984, 98 Stat. 211	Increased the debt limit to $1,520.0 billion	1,520.0
July 6, 1984, 98 Stat. 313	Increased the debt limit to $1,573.0 billion	1,573.0
October 13, 1984, 98 Stat. 475	Increased the debt limit to $1,823.8 billion	1,823.8
November 14, 1985, 99 Stat. 814	Increased the debt limit temporarily to $1,903.8 billion through December 6, 1985	1,903.8
December 12, 1985, 99 Stat. 1037	Increased the debt limit to $2,078.7 billion	2,078.7
August 21, 1986, 100 Stat. 818	Increased the debt limit to $2,111.0 billion	2,111.0
October 21, 1986, 100 Stat. 1874	Increased the debt limit temporarily to $2,300.0 billion through May 15, 1987	2,300.0
May 15, 1987, 101 Stat. 308	Increased the debt limit temporarily to $2,320.0 billion through July 17, 1987	2,320.0
July 30, 1987, 101 Stat. 542	Increased the debt limit temporarily to $2,320.0 billion through August 6, 1987	2,320.0
August 10, 1987, 101 Stat. 550	Increased the debt limit temporarily to $2,352.0 billion through September 23, 1987	2,352.0
September 29, 1987, 101 Stat. 754	Increased the debt limit to $2,800.0 billion	2,800.0
August 7, 1989, 103 Stat. 182	Increased the debt limit temporarily to $2,870.0 billion through October 31, 1989	2,870.0
November 8, 1989, 103 Stat. 830	Increased the debt limit to $3,122.7 billion	3,122.7
August 9, 1990, 104 Stat. 403	Increased the debt limit to $3,195 billion through October 2, 1990	3,195.0

TABLE 39.—STATUTORY LIMITS ON FEDERAL DEBT: 1981—CURRENT—Continued

[Dollars in billions]

Date and act	History of legislation	Amount of limit
October 2, 1990, 104 Stat. 878	Increased the debt limit temporarily to $3,195.0 billion through October 6, 1990	3,195.0
October 9, 1990, 104 Stat. 894	Increased the debt limit temporarily to $3,195.0 billion through October 19, 1990	3,195.0
October 19, 1990, 104 Stat. 1030	Increased the debt limit temporarily to $3,195.0 billion through October 24, 1990	3,195.0
October 25, 1990, 104 Stat. 1075	Increased the debt limit temporarily to $3,195.0 billion through October 27, 1990	3,195.0
October 28, 1990, 104 Stat. 1086	Increased the debt limit temporarily to $3,230.0 billion through November 5, 1990	3,230.0
November 5, 1990, 104 Stat. 1388	Increased the debt limit to $4,145.0 billion	4,145.0

TABLE 40.—HISTORICAL TABLE: RECONCILIATION BILLS

Reconciliation bills	Passed by Congress
Omnibus Reconciliation Act of 1980	December 3, 1980 (P.L. 96–499).
Omnibus Budget Reconciliation Act of 1981	July 31, 1981 (P.L. 97–35).
Omnibus Budget Reconciliation Act of 1982	August 18, 1982 (P.L. 97–253).
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).	August 19, 1982 (P.L. 97–248).
Omnibus Budget Reconciliation Act of 1983	April 5, 1984 (P.L. 98–270).
Deficit Reduction Act of 1984	June 27, 1984 (P.L. 98–369).
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).	April 7, 1986 (P.L. 99–272).
Omnibus Budget Reconciliation Act of 1986	October 21, 1986 (P.L. 99–509).
Omnibus Budget Reconciliation Act of 1987	December 22, 1987 (P.L. 100–203).
Omnibus Budget Reconciliation Act of 1989	November 22, 1989 (P.L. 101–239)
Omnibus Budget Reconciliation Act of 1990	October 27, 1990 (P.L. 101–508).

Section 2. Description of Proposals Affecting Programs Within the Jurisdiction of the Committee on Ways and Means [1]

MEDICARE

1. PPS Update

Current law and background

The overall increase in PPS payment rates each year is determined by an update factor, and applies to payments for discharges occurring on or after October 1 of each year. The updates for payments for many other covered Medicare services, specifically services covered under part B, generally occur on January 1 of each year.

Since 1987, payments for the services of physician assistants in hospitals have been paid separately under part B. Prior to this change, the cost of the services of physician assistants was included in the DRG payments to hospitals. OBRA 1986 required HCFA to reduce payments otherwise made to hospitals and skilled nursing facilities to offset payments to physician assistants under part B. Authority for the offset was repealed in OBRA 1990.

Description of proposal

The budget proposes to move the hospital update to January 1, saving $390 million in fiscal year 1992.

The budget also proposes to save an additional $10 million in fiscal year 1992 by reducing the annual update to reflect the cost of physician assistant services that had been included in the DRG payment prior to 1987.

2. Indirect Medical Education

Current law and background

Medicare currently pays PPS teaching hospitals for the indirect costs associated with approved intern and resident programs. These indirect costs may be due to a variety of factors, such as extra demands placed on hospital staff due to the teaching activity, additional tests and procedures ordered by residents, or more severely ill patients treated at teaching hospitals. The payment adjustment is currently based on a formula that increases the Federal portion of the DRG payment by 7.7 percent. Each 10 percent increase in the hospital's intern and resident to bed ratio on a curvilinear basis (an increase in the resident to bed ratio does not result in a proportional increase in payment).

---

[1] All outlay savings estimates used throughout this section are from the Congressional Budget Office. The 5-year numbers can be found in table 27 of section 1 in this part.

Description of proposal

The budget proposal would reduce the factor used to calculate the payment adjustment for hospital indirect medical education costs from 7.7 to 3.2 percent over a 5-year period. The proposal would also redefine the ratio used to calculate the adjustment from the ratio of a hospital's number of interns and residents to the hospital's number of beds to a value based on the ratio of interns and residents to the hospital's average daily occupancy. These proposals would save $1,040 in fiscal year 1992.

3. Direct Medical Education

Current law and background

Under current law, teaching hospitals also receive additional payment for the direct costs of medical education programs, such as the salaries and other education costs of interns, residents, nurses, and allied health professionals. These costs are not included in the PPS payment rates. Instead, payments for the direct costs of graduate medical education are based on Medicare's share of each hospital's direct costs per resident in a base year updated each year by the consumer price index. Payments are drawn from both part A and part B of Medicare.

Description of proposal

The budget proposal would limit Medicare payments for the direct costs of graduate medical education (i.e., internship and residency training programs for physicians) through the establishment of a per resident payment amount based upon the average salaries paid to residents nationally. Payments in support of primary care residents would be weighted at 240 percent of the average salary amount, non-primary care residents in their initial residency period would be weighted at 140 percent, and nonprimary care residents beyond their initial residency period would be weighted at 100 percent. The proposal would save a total of $120 million in fiscal year 1992.

4. DRG Payment Window

Current law and background

Outpatient services provided by a hospital within a certain period preceding an admission are considered to be a part of the admission. Payment for these services are included within the payment for the admission under the DRG payment system. This period is known as the DRG payment window. OBRA 1990 extended this window from 24 to 72 hours preceding the admission. There is currently no limit on payments for outpatient hospital services provided after discharge.

Description of proposal

The budget proposes to extend the DRG payment window to include services provided within 15 days of discharge. This would save an estimated $30 million in fiscal year 1992.

5. Eliminate Return on Equity (ROE) Payments to Skilled Nursing Facilities (SNFs)

Current law and background

Medicare currently pays a return on equity (ROE) for proprietary skilled nursing facilities. Equity includes all capital, net of depreciation, used for patient care, including loans from investors. SNFs are the only class of providers for which Medicare pays ROE.

Description of proposal

The budget proposes to eliminate ROE payments to skilled nursing facilities, saving $45 million in fiscal year 1992.

6. Update for Physician Fees

Current law and background

Current law provides that prevailing charges are updated annually by an economic index known as the Medicare Economic Index, or MEI. Since 1984, Congress has generally established the update percentage by legislation.

Description of proposal

The budget includes a regulatory proposal to make technical changes in the calculation of the MEI.

7. Medicare Volume Performance Standard for 1991

Current law and background

OBRA 1989 established a system of Medicare volume performance standards (MVPSs) for determining the update to physician services after 1992. OBRA 1990 established the MVPS for fiscal year 1991, computed as the baseline rate of growth, minus the change in the baseline due to the amendments included in OBRA 1990, minus 2 percentage points. The update in 1993 will be based, in part, on how the growth in actual expenditures compares to the 1991 MVPS targets.

Description of proposal

The budget includes a proposal to reduce the 1993 MEI by 0.9 percentage points to achieve the reduction that would have occurred if the 1991 MVPS had been set by multiplying the three factors together, as opposed to adding them as specified in OBRA 90.

8. Anesthesiology Services

Current law and background

Payment for anesthesia services is based on a fee schedule. Physicians are also paid for supervising the services of certified registered nurse anesthetists (CRNAs) who provide anesthesia services. The combined payments to a CRNA and the supervising physician can exceed the amount that would be paid if the physician had personally performed the service.

Description of proposal

The budget proposes to reduce the amount paid to physicians who supervise anesthesia services provided by CRNAs, such that the combined payments would be the same as when the physician personally provided the service. The amount paid for supervision would be the difference between the amount paid to the CRNA and the amount that would be payable to a physician for the same service. In addition, the increase in CRNA payment rates made in OBRA 90 would be repealed. This proposal would save an estimated $95 million in fiscal year 1992.

9. Payments for Assistants-at-Surgery

Current law and background

Medicare currently pays for the services of physicians and physician assistants who act as assistants-at-surgery. In general, the primary surgeon decides when the use of an assistant is appropriate. The payment for the assistant is in addition to any amount paid to the primary surgeon.

Description of proposal

The budget proposes to reduce the payment made to the primary surgeon on a case-by-case basis for any payments made to an assistant-at-surgery. Exceptions to this policy would be made for procedures where the use of an assistant is required due to the nature of the surgery. This proposal is projected to save $35 million in fiscal year 1992.

10. Eliminate Payments for Specimen Collections

Current law and background

Physicians may bill for the collection and handling of blood and urine specimens when the test is performed by an independent laboratory.

Description of proposal

The budget proposes to eliminate separate payments for these services when provided during an office visit. This would save $10 million in fiscal year 1992.

11. Payments for Covered Drugs

Current law and background

Medicare covers the cost of drugs that are provided on an outpatient basis when the drug cannot be self-administered. In general, this coverage is limited to drugs that must be injected. Payment for these drugs is based on a reasonable charge methodology.

Description of proposal

The budget proposes to limit payments for covered drugs to the wholesale price of the drug less 15 percent. This would save an estimated $10 million in fiscal year 1992.

12. Payments for Radiology and Other Diagnostic Tests

Current law and background

Radiology services and other diagnostic tests are paid on the basis of two components, a professional and a technical component. OBRA 1990 included a provision that limited the reasonable charge for diagnostic tests, other than radiology and clinical laboratory tests, to the national median of such payment amounts.

Description of proposal

Under this proposal, the Department would collect data that would determine the cost of providing the technical components of radiology and other diagnostic tests when performed by a reasonably efficient provider of services. Medicare payments for these services would then be adjusted accordingly. The proposal does not assume any savings in fiscal year 1992.

13. Clinical Laboratory Services

Current law and background

Clinical laboratory services are currently paid on the basis of area-wide fee schedules, subject to a nationwide cap equal to a percentage of the median value of the area-wide schedules. OBRA 1990 reduced the nationwide cap to 88 percent of the national median.

Claims for laboratory services are reimbursed at 100 percent of the fee schedule amount, and are not subject to the 20-percent coinsurance amount that applies to most other part B services.

Laboratory fees generally are updated annually by the CPI. OBRA 1990 reduced the updates in 1991 through 1993 to 2 percent.

Description of proposals

The budget proposes to make payments for clinical laboratory services subject to the 20-percent coinsurance amount. This would reduce Medicare's payments for these services by an estimated $510 million in fiscal year 1992.

In addition, the budget proposes that the 2-percent update in 1992 and 1993 would apply only to services with a fee schedule amount that is below the national cap. This would save an estimated $20 million in fiscal year 1992.

14. Durable Medical Equipment

Current law and background

OBRA 1987 established local area fee schedules for Durable Medical Equipment (DME), effective January 1, 1989. OBRA 1990 created national upper and lower limits on the local fee schedules. The upper limit for each item is equal to 100 percent of the national average payment. The lower limit is equal to 85 percent of the national average amount. These limits are being phased in over a 3-year period.

Payments for oxygen services also are based on a fee schedule. According to a study conducted by the Office of the Inspector General, Medicare payments for oxygen are higher than the payments of other insurers.

Orthotic and prosthetic devices are not subject to the system of national limits. Payments for these devices and services are being phased into regional fee schedules.

Enteral nutritional products and supplies are used by patients who, as a result of chronic illness or traumatic injury, cannot ingest food orally. Under current law, payment for enteral supplies is the lowest of the actual charge, the customary charge, the prevailing charge, a "lowest charge level" screen, and an inflation adjusted charge.

Description of proposals

The budget includes four proposals in this area. These proposals would save a total of $55 million in fiscal year 1992.

The first proposal would define the upper and lower limits as based on the national median fee, instead of the national average.

The second proposal would reduce current payments for oxygen services and supplies by 5 percent.

The third proposal would make payments for orthotic and prosthetics devices and services subject to the same upper and lower national limits as apply to items of durable medical equipment.

The fourth proposal would establish a fee schedule for enteral and parenteral equipment and supplies. Payment for these items would be subject to the same upper and lower limits as durable medical equipment items.

15. Hospital Outpatient Department Services

Current law and background

Generally, payment for hospital outpatient department (OPD) services is on a cost-related basis. Special limits apply for ambulatory surgery services, and for radiology and other diagnostic tests. Overall, hospital outpatient department services represent one of the fastest growing components of the part B program.

The coinsurance amount for services provided in OPDs is 20 percent of the OPDs' charges, as opposed to 20 percent of Medicare's cost-related payment amount.

OBRA 1990 established a schedule for consideration of reforms in the methodology for paying for services provided in hospital OPDs. The Secretary is to report to Congress on a prospective payment methodology for OPD services in September 1991.

Description of proposal

The budget proposes to phase out cost-related payments for most OPD services. Payments for most outpatient surgery would be limited to the lesser of the rate currently paid to free-standing ambulatory surgical centers and the average OPD costs for the same procedure. Payments for radiology, other diagnostic tests, and minor surgical procedures not currently reimbursed in ambulatory surgical centers would be based on the technical component of the fees established under the physician RB RVS. In each case, the payment would be the same whether the services is provided in an OPD, free-standing facility, or physician office.

The coinsurance obligation would be changed to 20 percent of Medicare's payment.

The update to the rates paid to free-standing ambulatory surgical facilities would be changed from July 1 to January 1 to conform with the updates for most other Part B services.

16. Payments to Providers for Physical and Respiratory Therapy Services

Current law and background

Medicare pays for the services of physical and respiratory therapists provided in hospital outpatient departments (OPDs), skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs). When these services are provided under arrangement, as opposed to when they are provided by employees of such facilities, Medicare's payment is based on an amount that is equivalent to the salary that would be paid to an employee who provides the service. This "salary equivalence" was initially determined in 1983. Since then, it has been updated for inflation by 0.6 percent per month. This update reflects the level of inflation in salaries that was projected in 1983. Actual inflation in salaries since 1983 has been somewhat lower.

Description of proposal

The salary allowances for the cost of physical and respiratory therapy provided under arrangements would be adjusted to reflect actual inflation in salaries, saving an estimated $10 million in fiscal year 1992.

17. Home Health Cost Limits

Current law and background

Home health agency services are reimbursed on a cost-related basis. Cost limits are used to determine the reasonable costs. OBRA 1986 required that uniform, aggregate limits be applied across all types of disciplines providing services through a home health agency.

Description of proposal

The aggregate cost limits would be replaced with a system of separate limits for each discipline providing services. This would save an estimated $90 million in fiscal year 1992.

18. Uniform Medicare Secondary Payor Employee Size Threshold

Current law and background

Medicare is a secondary payer under specified circumstances when Medicare beneficiaries are covered by other third party payers, including employer group health plans, automobile, no-fault and liability insurance. Under the working aged provisions, Medicare is secondary to employer group health plans with 20 or more employees.

In the case of disabled Medicare beneficiaries, Medicare is secondary payer for individuals covered by a "large group health plan" defined as an employer or employee organization plan of an employer that employees at least 100 employees.

Description of proposal

The size of firm threshold under the Medicare secondary payer provisions for the disabled and for end stage renal disease (ESRD) beneficiaries would be amended so that Medicare is secondary to employer group heath plans that cover employers with 20 or more employees. The definition of individuals subject to the disabled secondary payer provisions would be revised to include only those beneficiaries covered under a group health plan by reason of current employment or the employment of a family member. This would save an estimated $80 million in fiscal year 1992.

19. Part B Premium

Current law and background

From 1984 through 1990, the monthly part B premium has been set at 25 percent of program costs for the elderly and adjusted for interest income to provide for an appropriate contingency margin. The remaining 75 percent is covered by general revenues.

For years 1991 through 1995, the part B premium is set at a level to reflect CBO estimates of the level necessary for the part B premium to cover 25 percent of program costs through 1995: $29.90 in 1991, $31.80 in 1992, $36.60 in 1993, $41.10 in 1994 and $46.10 in 1995.

Description of proposal

The budget proposes to income-test part B premiums for Medicare beneficiaries. The proposal would reduce the part B subsidy for individuals with annual adjusted gross incomes (AGI) above $125,000 and couples with AGIs above $150,000. These individuals would be required to pay a part B premium equal to 75 percent of total part B program costs. For individuals with incomes above this threshold, the monthly part B premium would be $95.40 in 1992, increasing to $138.30 in 1995. The proposal would save an estimated $27 million in fiscal year 1992.

20. Coordinated Care Initiatives

Current law and background

Medicare currently allows beneficiaries to enroll in health maintenance organizations (HMO). For beneficiaries electing to enroll in an HMO, these organizations provide coordinated care across the entire range of Medicare covered benefits. For beneficiaries not electing the HMO option, all Medicare covered services are provided through the traditional health care delivery systems.

Description of proposal

The Administration's budget includes a proposal to fund the development of coordinated care initiatives. This would include the coordination of the delivery of medical services provided by a variety of different entities. These initiatives would emphasize primary and preventive care and, according to the Administration's budget, would have the potential of providing improved health care at a lower cost. These initiatives would cost $40 million in fiscal year 1992.

SOCIAL SECURITY AND RAILROAD RETIREMENT

1. Social Security Retirement Test

Current law and background

Social Security beneficiaries with earnings above specific thresholds may have some or all of their benefits withheld to take into account these earnings. In 1991, beneficiaries under age 65 have their benefits reduced by $1 for every $2 of earnings over $7,080. Beneficiaries age 65–69 have their benefits reduced by $1 for every $3 of earnings over $9,720. This threshold is projected by the Congressional Budget Office to rise to $10,200 in 1992, $10,680 in 1993, and $11,400 in 1994 under automatic provisions. The retirement test does not apply to beneficiaries age 70 and older.

Description of proposal

The annual earnings threshold under the retirement test for individuals age 65–69 would be increased by $800 in 1992 and $200 in 1993. The increases would not be cumulative, and the threshold would continue at its current-law level in 1994 and thereafter. Under the proposal, the thresholds would be $11,000 in 1992, $10,880 in 1993, and $11,400 in 1994.

2. Social Security Administration (SSA) Staffing (nonlegislative proposal)

During the 1980's, SSA staff was reduced by 20 percent. Staffing levels were essentially stabilized with the fiscal year 1991 budget, and the fiscal year 1992 budget calls for a modest increase of 1,258 Full Time Equivalents (FTEs) in SSA staffing, bringing total employment at the agency to 64,530. About two-thirds of this increase, or 800 FTEs, would be funded by a temporary supplemental appropriation which the Administration is requesting to implement the *Zebley* Supreme Court decision. The *Zebley* decision requires SSA to reevaluate the disabilities of a large number of children whom it previously denied Supplemental Security Income benefits.

Disability case backlogs are rising. Currently, SSA takes 3 months to process a disability claim. Even if the President's FY 1992 request is approved in full, this waiting period is expected to increase to 6 months next year. In addition, about 60,000 disability applications have not been assigned to a disability examiner for action due to already heavy workloads and increasing numbers of applications.

3. Social Security Benefits for Railroad Retirement Dependents

Current law and background

Railroad retirement tier 1 benefits are in most cases identical to Social Security benefits and are computed under the Social Security benefit formula. However, benefits for certain dependent family members that would be payable if the worker had worked under Social Security are not paid at all under railroad retirement. These dependents include the child of a retired or disabled worker, the retired divorced spouse of a railroad worker who has not yet retired, the spouse or divorced spouse of a disabled worker under age 62, and a surviving spouse who elects to withdraw pre-1974 taxes paid under railroad retirement in a lump sum rather than receiving monthly benefits. In addition, railroad retirement does not pay a lump sum death benefit if the recipient of the benefit is entitled to a railroad retirement benefit for the month of the worker's death.

Description of proposal

Social Security benefits would be paid to those family members of railroad workers who do not receive benefits that they would be eligible for had the worker been employed under Social Security. It appears that the claims would be processed by the Social Security Administration.

CHILD SUPPORT ENFORCEMENT

1. Incentive Payments

Current law and background

Under the Child Support Enforcement program the Federal government makes incentive payments to States in proportion to a measure of their cost-effectiveness, which is the ratio of child support collections to administrative costs. Under the formula, each State receives an incentive payment equal to at least 6 percent of the State's total amount of AFDC child support collections for the year. The same formula applies to non-AFDC case collections, except that non-AFDC collections are capped at 115 percent of AFDC collections. The amount of the State's incentive payment could reach as high as 10 percent of collections, depending on the State's cost-effectiveness ratio.

Description of proposal

The maximum Federal incentive payments to States for child support enforcement collections would be reduced from 10 to 5 percent. New incentives rewarding other aspects of child support enforcement, such as establishing paternities or support obligations, would be added up to 10 percent of collections on behalf of AFDC families. In addition, the proposal would require States to reinvest these incentive payments in programs benefiting children. The Administration also proposes legislation to extend child support services to recipients of food stamps.

2. Fees

Current law and background

State child support enforcement programs must charge application fees for child support enforcement and paternity establishment services to non-AFDC families of up to $25. States may pay the fees rather than charge clients, and in practice most States set nominal fees.

Description of proposal

States would be required to charge an application fee of $25 for non-AFDC cases and an annual user fee of $25 thereafter. The user fee would be charged only in cases which receive support collections through the State. States would be permitted to increase these fees to $50 each if they charged only individuals with incomes above 185 percent of the poverty line. States could also absorb the fees rather than charge clients.

SUPPLEMENTAL SECURITY INCOME

1. Fee for Administration of State Supplementation

Current law and background

The Social Security Administration administers the State supplementation of SSI benefits in 17 States and the District of Columbia. No fee is charged for this service.

Description of proposal

The Social Security Administration would be authorized to charge States fees for the Federal cost of administering State supplemental SSI payments.

2. Collection of SSI Overpayments

Current law and background

The Social Security Administration (SSA) can collect overpayments to SSI recipients if such collection does not violate "equity and good conscience." Furthermore, SSA cannot collect the overpayment by reducing the SSI benefit without a written agreement with the recipient, and the amount of the collection cannot exceed the lesser of the benefit amount or 10 percent of the recipient's total income. However, once a recipient goes off SSI and onto title II Social Security benefits, no offset collection is available.

Description of proposal

The Social Security Administration would be authorized to collect SSI overpayments by reducing title II Social Security benefits paid to those no longer eligible for SSI.

UNEMPLOYMENT COMPENSATION

Current law and background

The Federal Government grants funds to the States for administration of the unemployment insurance system. When unemployment increases, the President usually asks for a supplemental appropriation to cover the costs of additional unemployment insurance claims.

Description of proposal

A $100 million supplemental appropriation would be passed to cover increased State administrative expenditures resulting from higher unemployment insurance claims. However, more recent unofficial estimates suggest the supplemental appropriation should be about $200 million. The Administration has asserted that there is enough room within the domestic spending cap established by the Budget Enforcement Act of 1990 to allow for this appropriation without triggering a sequestration. If this turns out not to be true, the Department of Labor has proposed to rescind Summer Youth program funds to make room for this appropriation.

CHILD WELFARE SERVICES AND FOSTER CARE

1. Title IV-B Funding

Current Law and background

The title IV-B child welfare services program authorizes $325 million per fiscal year to the States for child welfare services. For fiscal year 1991, $273 million was appropriated for the program.

Description of proposal

Funding for the title IV-B child welfare services program would equal $364 million for fiscal year 1992, an increase of $90 million over the prior fiscal year. The increased funds are linked to a proposal which reforms financing of foster care administrative costs (see following proposal). $10 million would be used for demonstration projects to test the effectiveness of intensive, home-based family intervention services as a means of preventing foster care placement.

2. Prohibition on reimbursement for preplacement activities

Current law and background

States receive Federal reimbursement under the title IV-E foster care program for child placement services and administrative costs at a rate of 50 percent. Current law requires States to undertake certain preplacement activities which are reimbursed in this category. For example, States must make reasonable efforts to prevent or eliminate the need for the removal of a child from the child's home. In addition, the State is required to develop a case plan and prepare for and participate in a judicial proceeding.

Description of proposal

Would prohibit Federal reimbursement for certain, unspecified expenditures related to "preplacement" activities under the title IV-E foster care program.

AFDC AND THE TITLE XX SOCIAL SERVICES BLOCK GRANT

Current law and background

Generally, administrative costs under the Aid to Families with Dependent Children program are reimbursed to the States on an open-ended entitlement basis at a rate of 50 percent, except that an enhanced match of 90 percent is available for the costs associated with designing, developing, and operating automated data systems.

The title XX social services block grant is a capped entitlement program that provides funds to the States for a broad range of social services. No State match is required under this block grant.

Description of proposal

Would consolidate a number of programs and turn the programs over to the States in the form of a block grant, with the goal of providing Federal funds in a more flexible form. Would include in the list of possible program candidates the following programs: (1) State administrative expenses for Medicaid, AFDC and Food Stamps; and (2) the title XX social services block grant.

TRADE ADJUSTMENT ASSISTANCE

1. Terminate the TAA Program

Current law and background

The Trade Adjustment Assistance (TAA) program for workers and firms has been amended and reauthorized several times under the Trade Act of 1974 since it was first established in 1962, and currently extends until September 30, 1993.

This special assistance program provides weekly cash allowances, training benefits, and job search and relocation allowances to workers and technical assistance to firms and industries that are certified by the Departments of Labor or Commerce as adversely impacted directly by increased imports. The weekly cash payments to workers are an extension of unemployment compensation (UC) weekly benefit amounts, payable upon exhaustion of UC for up to 78 weeks of UC and TAA payments combined, conditional generally on worker participation in an approved training program. Benefits to firms consist of technical assistance to prepare a petition for certification or the required adjustment plan and/or to implement an approved plan. The benefits for workers are an entitlement program.

Description of proposal

Legislation will be proposed by the administration to terminate the separate TAA program for workers as of October 1, 1991, and to serve workers displaced by imports through the Economic Dislocation and Worker Adjustment Assistance program under Title III of the Job Training Partnership Act beginning in fiscal year 1992. Workers collecting TAA benefits during the week including September 30, 1991, would continue to collect the balance of their TAA entitlements. The administration also proposes termination of the discretionary TAA program for firms in 1992.

SELECTED TAX, USER FEE, AND OTHER PROPOSALS [2]

1. State and Local Government Employee HI Coverage

Current law and background

Prior to the enactment of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), State and local employees were covered under the Medicare system only if the State and the Secretary of Health and Human Services entered into a voluntary agreement providing for coverage under the Social Security and Medicare programs. In COBRA, the Congress extended Medicare coverage (and the corresponding hospital insurance payroll tax) on a mandatory basis to State and local government employees hired after March 31, 1986, for services performed after that date.

---

[2] Many of the descriptions of these proposals are from: Joint Committee on Taxation, Summary of Revenue Provisions in the President's Budget Proposal for Fiscal Year 1992 (JCS-1-91), February 25, 1991.

State and local workers hired prior to April 1, 1986 by a governmental entity with continuous employment with that entity since that date are not required to be covered under Medicare. State and local governments are not required to pay the Hospital Insurance (HI) payroll tax of 1.45 percent on behalf of these workers, nor do the employees.

Description of proposal

State and local employees hired before April 1, 1986 would be required to be covered under Medicare. This proposal would produce additional revenues of $1.1 billion in fiscal year 1992, according to the President's budget.

2. Survey and Certification User Fees

Current law and background

The Health Care Financing Administration (HCFA) administers the survey and certification program that surveys various health facilities that provide services under Medicare and Medicaid, and laboratories that must be certified under the Clinical Laboratory Improvement Act of 1988 (CLIA). Under CLIA, laboratories are charged a fee for the certification process. The costs of the Medicare and Medicaid survey and certification processes are currently financed out of the appropriations for program management within HCFA.

Description of proposal

The Administration's budget includes a proposal to fund the Medicare and Medicaid facility survey and certification programs through user fees levied on the facilities being surveyed, including hospitals, nursing homes, and facilities providing services to end-stage renal disease (ESRD) beneficiaries. The CBO estimates that the revenues from these fees would provide net savings of $151 million in fiscal year 1992.

3. Pension Benefit Guaranty Corporation and the Budget

The President reports that overall funding of defined benefit pensions is good. However, a minority of plans are still underfunded. The Administration estimates that these underfunded plans have $20 billion to $30 billion in unfunded pension liabilities. The President reports that PBGC's deficit over the next 30 years is likely to climb to $6 billion and, under pessimistic economic assumptions, could reach $20 billion. However, premium increases included in OBRA 1990 should provide a positive cash flow through the end of the century.

The President will propose legislation to clarify and improve the status of PBGC bankruptcy claims, to revise the legal treatment of contingent early retirement benefits (such as shutdown benefits), to allow PBGC to become a member of creditors' committees in bankruptcy, and to tighten interest rates used to determine certain contributions to underfunded plans.

4. Targeted Jobs Tax Credit

Current law and background

The targeted jobs tax credit is available on an elective basis for hiring individuals from nine targeted groups. The credit generally is equal to 50 percent of the first $6,000 of qualified first-year wages paid to a member of a targeted group. Thus, the maximum credit generally is $2,400 per individual. With respect to economically disadvantaged summer youth employees, however, the credit is equal to 40 percent of up to $3,000 of wages, for a maximum credit of $1,200.

The credit is available with respect to targeted-group individuals who begin work for the employer before January 1, 1992.

Description of proposal

The President's budget proposal would extend the credit for one year. Therefore, the credit would be available for workers who begin work for the employer before January 1, 1993. (Thus, appropriations would also be authorized, as under present law, for administrative and publicity expenses related to the credit extension.)

5. Deduction for Special Needs Adoption

Current law and background

The Tax Reform Act of 1986 (the 1986 Act) repealed the deduction for adoption expenses associated with special needs children, effective for taxable years beginning on or after January 1, 1987. Under prior law, a deduction of up to $1,500 of expenses associated with the adoption of special needs children was allowed. The 1986 Act provided, as a substitute for the deduction, a new outlay program under the existing Adoption Assistance Program to reimburse expenses associated with the adoption process of these children. The Title IV-E Adoption Assistance outlay program provides assistance for adoption expenses for these special needs children receiving federally assisted adoption assistance payments as well as special needs children in private and State-only programs.

One component of the Adoption Assistance Program requires States to reimburse certain costs incurred for special needs children. The Federal Government shares 50 percent of these costs up to a maximum Federal share of $1,000 per child. Reimbursable expenses include those associated directly with the adoption process such as legal costs, social service review, and transportation costs.

Description of proposal

The President's budget proposal would permit a deduction for certain incurred expenses associated with the adoption of special needs children up to a maximum of $3,000 per child. Eligible expenses would be limited to those: (1) directly associated with the adoption process and (2) that are of a type eligible for reimbursement under the Adoption Assistance Program. These include court costs, legal expenses, social service review, and transportation costs. This deduction would be allowed for eligible expenses regardless of the level of reimbursement allowed under the Adoption Assistance Program. Any reimbursement of expenses that were previously deducted would be included in income in the year in which the reimbursement occurred.

The proposal also clarifies that all reimbursements are includable in income to the recipient unless deductible under this provision.

The proposal would be effective for calendar years after December 31, 1991.

6. Extend and Expand Railroad Unemployment Insurance Fund

Current law and background

The railroad unemployment and sickness benefit program is financed by payroll taxes paid by railroad employers. The employees themselves do not contribute. Currently, the taxable earnings base is the first $600 of each employee's monthly earnings. The payroll tax rate may vary from 0.5 percent to 8.0 percent (depending on the unemployment experience of the employer).

The Technical and Miscellaneous Revenue Act of 1988 provided an exemption from the railroad unemployment tax rate for public commuter railroads in 1989 and 1990. Instead, such public commuter railroads reimbursed the unemployment system for the amount of actual unemployment and sickness benefits paid during those years to their employees. Starting in 1991, these railroads will again be subject to payroll taxes on the same basis as other railroads.

Description of proposal

The President's budget proposal would extend the present-law exemption provided to commuter railroads, effective January 1, 1991. The proposal would also extend the exemption to Amtrak, effective January 1, 1991.

7. Low-Income Rental Housing Tax Credit

Current law and background

A tax credit is allowed in annual installments over 10 years for qualifying low-income rental housing, which may be newly constructed, or newly acquired existing residential rental property that is substantially rehabilitated.

The low-income housing credit is scheduled to expire after December 31, 1991.

Description of proposal

The President's budget proposal would extend the credit for 1 year, through December 31, 1992.

8. Deduction for Health Insurance Costs of Self-Employed Individuals

Current law and background

Under present law, self-employed individuals are entitled to deduct 25 percent of the amount paid for health insurance for the individual and the individual's spouse and dependents. The deduction expires for taxable years beginning after December 31, 1991. An employer's contribution to a plan providing accident or health coverage is generally excludable from an employee's income.

Description of proposal

The President's budget proposal would extend the 25-percent deduction for 1 year.

Section 3. Description of the Congressional Budget Process and Sequestration Under the Gramm-Rudman-Hollings Act

INTRODUCTION

In 1974, Congress reformed its procedures and institutions for dealing with budgetary matters by enacting the Congressional Budget and Impoundment Control Act of 1974. The Act established House and Senate Budget Committees and the Congressional Budget Office and set up a process for the annual adoption and enforcement of budget resolutions.

After a decade of experience with the Congressional Budget Act, Congress faced persistent high deficits and increasing budgetary deadlock. In 1985, it enacted legislation aimed at bringing the Federal budget into balance by the early 1990s. That legislation is commonly referred to as the Gramm-Rudman-Hollings (GRH) Act after its three primary sponsors in the Senate (Senators Phil Gramm, Warren Rudman, and Ernest Hollings).

The GRH Act established a series of declining annual deficit targets and created an automatic spending-reduction process (known as "sequestration") intended to ensure that the deficit targets were adhered to even if Congress and the President failed to reduce the deficit sufficiently through legislative action. Congress made significant changes in the GRH Act in 1987 and 1990. The most recent changes, the Budget Enforcement Act (BEA) of 1990, were made in conjunction with the enactment of a 5-year deficit-reduction accord covering fiscal years 1991-95. The accord, embodied in the budget resolution for fiscal year 1991 (H. Con. Res. 310), is intended to achieve about $500 billion in deficit reduction over the 5-year period. Under the BEA, the concept of fixed deficit targets is abandoned and more complex yet flexible sequestration procedures are substituted. The procedures involve, in addition to adjustable deficit targets, limits on discretionary spending (that also may be adjusted) and pay-as-you-go procedures that apply to revenues and direct spending.

The BEA is a long, complicated act and many of its provisions have yet to be tested. Although this section reflects the best current interpretation of the BEA, practical experience is likely to modify some of the conclusions presented here.

Fiscal year 1992 marks the 17th fiscal year of congressional operations under the Congressional Budget Act and the 7th fiscal year subject to the requirements of the sequestration process. Sequestration reductions were made in 4 of the last 6 fiscal years (fiscal years 1986-91), although Congress rescinded or modified their application in most instances.

This section provides a brief overview of the Congressional Budget Act and a more detailed explanation of the GRH Act, describes the basic features of the sequestration process, reviews sequestration actions for fiscal years 1986–91, and discusses the President's budgetary proposals for fiscal year 1992 in terms of their conformity to budget enforcement procedures.

BRIEF OVERVIEW OF THE CONGRESSIONAL BUDGET PROCESS

The Congressional Budget and Impoundment Control Act of 1974 (P.L. 93–344; 88 Stat. 297–339) was signed into law by President Richard Nixon on July 12, 1974, and has been amended several times since then. Titles I–IX are referred to as the Congressional Budget Act and title X is referred to as the Impoundment Control Act. The most recent changes to the Congressional Budget Act occurred last year as part of the BEA, which also revised the sequestration process under the GRH Act. Some of the changes in the Congressional Budget Act were designed to make congressional budget decisions conform to the deficit-reduction goals set forth in the fiscal year 1991 budget resolution and in the GRH Act.

Under the Congressional Budget Act, three new institutions were established: the House Budget Committee, the Senate Budget Committee, and the Congressional Budget Office (CBO). The primary duty of each Budget Committee is the development of an annual budget resolution. The budget resolution is a concurrent resolution, so it is not presented to the President and does not become law. Rather, the budget resolution serves as a guide for the consideration by Congress of budgetary legislation. Additionally, the Budget Committees manage any reconciliation legislation that may be required by the budget resolution to bring existing spending, revenue, and debt-limit laws into conformity with budget resolution policies. CBO serves as an independent and nonpartisan source of budgetary information and analysis for Congress.

Budget resolutions present congressional budgetary policy in general form, setting forth fiscal policy in terms of overall revenue, spending, deficit or surplus, and debt levels, and establishing spending priorities. Decisions regarding specific revenue and spending programs are made by the committees of jurisdiction, within the larger framework established by the budget resolution.

In past years, budget resolutions usually covered 3 fiscal years and were binding for the first year only. Under the changes made by the BEA, budget resolutions for the 5-year period covered by the budget accord must cover 5 fiscal years and are binding both for the first fiscal year and the sum of the 5 fiscal years.

Under the schedule laid out in the Congressional Budget Act, Congress is expected to complete action on the budget resolution and spending, revenue, and debt-limit legislation for a fiscal year by October 1. when the new fiscal year begins. (Sequestration under the GRH Act, if required for the fiscal year, would not occur until shortly after the adjournment of Congress for the session.) Table 1 sets forth the key dates of the congressional budget process timetable (a timetable for the sequestration process is presented in the next section). In practice, Congressional action on budget resolutions and major implementing legislation often is not completed by the prescribed deadlines and Congress adjourns for the session several weeks or months after the fiscal year has begun.

TABLE 1.—CONGRESSIONAL BUDGET PROCESS TIMETABLE

Deadline	Action to be completed
First Monday in February	President submits his budget to Congress.
February 15	Congressional Budget Office submits report on economic and budget outlook to Budget Committees.
Six weeks after President's budget is submitted.	Committees submit reports on views and estimates to respective Budget Committee.
April 1	Senate Budget Committee reports budget resolution.
April 15	Congress completes action on budget resolution.
May 15	Regular appropriations bills may be considered in the House (even if action on the budget resolution has not yet been completed).
June 10	House Appropriations Committee reports last regular appropriations bill.
June 30	House completes action on regular appropriations bills and any required reconciliation legislation.
July 15	President submits "Mid-Session Review" of his budget to Congress.
October 1	Fiscal year begins.

Once a budget resolution is in place, its policies are enforced by means of various points of order. The principal links between the Congressional Budget Act and the GRH Act are provisions in title VI of the Congressional Budget Act requiring that levels in the annual budget resolution conform to the applicable deficit targets set in the GRH Act (as they may be adjusted) and effectively requiring compliance with the pay-as-you-go procedures and discretionary spending limits (as they also may be adjusted). Table 2 provides information on the major points of order that may be raised under the Congressional Budget Act in the House and Senate.

The Senate modified the waiver requirement for many of these points of order so that an extraordinary majority—three-fifths of the full body (60 Members if all 100 Members have been sworn into office)—must vote affirmatively for the waiver request to be successful. For most of the point-of-order provisions, the three-fifths requirement remains in effect only for the duration of the GRH Act (through fiscal year 1995).

TABLE 2.—MAJOR POINTS OF ORDER UNDER THE CONGRESSIONAL BUDGET ACT [1]

Section of the act	Description	Application
301(g)	In the Senate, prohibits consideration of a budget resolution using more than one set of economic and technical assumptions.	Budget resolution, amendment, or conference report.
301(i)*	In the Senate, prohibits consideration of a reported budget resolution that would decrease the Social Security surplus in any fiscal year covered by the resolution.	Budget resolution (as reported).
302(c)* [602(d)].	Prohibits consideration of spending legislation from a committee until that committee files its spending suballocations under section 302(b). For fiscal years 1992 through 1995, by reference in section 602(d), this point of order applies only to suballocations made by the House and Senate Appropriations Committees under section 602(b).	Bill, joint resolution, amendment, motion, or conference report.
302(f)* [602(c)].	Prohibits consideration of spending legislation which: In the House, exceeds a committee's section 302(b) suballocation; or In the Senate, exceeds a committee's section 302(a) allocation (with the exception of the Senate Appropriations Committee) or section 302(b) suballocation, including legislation exceeding a committee's Social Security outlay allocation. For fiscal years 1991 through 1995: Section 602(c) applies the point of order under section 302(f) to any allocation or suballocation made under sections 602 (a) or (b), including Social Security outlay allowances in the Senate (section 602(c) does not apply in the House for fiscal year 1991).	Bill, joint resolution, amendment, motion (in the Senate), or conference report.

TABLE 2.—MAJOR POINTS OF ORDER UNDER THE CONGRESSIONAL BUDGET ACT [1]—Continued

Section of the act	Description	Application
	Section 602(e) exempts from a point of order under section 302(f) any deficit-neutral legislation considered in the House as long as any revenue increases required by the budget resolution have been met.	
303(a)	Prohibits consideration of spending, revenue, or debt-limit legislation for a fiscal year before a budget resolution for that year has been adopted. Section 303(a) does not apply in the House after May 15 to the consideration of regular appropriations bills for the upcoming fiscal year. For fiscal years 1991–95, section 303(a) does not apply in the House after April 15 to consideration of deficit-neutral legislation described in section 602(e).	Bill, joint resolution, amendment, motion, or conference report.
305(a)(1)	In the House, prohibits consideration of a reported budget resolution until a 5-day layover period has elapsed.	Budget resolution (as reported).
305(b)(2)*	In the Senate, prohibits consideration of nongermane amendments to budget resolutions (and by reference also prohibits nongermane amendments to reconciliation legislation (see section 310(e)).	Amendment.
306*	Prohibits consideration of legislation within the jurisdiction of the House and Senate Budget Committees not reported by those committees.	Bill, resolution, amendment, motion, or conference report.
309	In the House, prohibits consideration of an adjournment resolution for more than 3 calendar days in July until the House has approved all regular appropriations bills for the upcoming fiscal year.	Resolution.
310(d)*	Prohibits consideration of amendments to reconciliation measures that are not deficit neutral (including, in the House, any reconciliation legislation considered pursuant to section 604).	Amendment.
310(e)*	In the Senate (by reference to section 305(b)), prohibits consideration of nongermane amendments to reconciliation legislation.	Amendment.

TABLE 2.—MAJOR POINTS OF ORDER UNDER THE CONGRESSIONAL BUDGET ACT [1]—Continued

Section of the act	Description	Application
310(f)	In the House, prohibits consideration of an adjournment resolution for more than 3 calendar days in July until the House has completed action on any required reconciliation legislation.	Resolution.
310(g)*	Prohibits consideration of reconciliation legislation—including, in the Senate, any special reconciliation legislation triggered by section 258C of the Gramm-Rudman-Hollings Act—that recommends changes in Social Security.	Bill, resolution, amendment, or conference report.
311(a)* [605(a)].	Prohibits consideration of legislation that would breach the aggregate spending or revenue levels in the budget resolution—including, in the Senate, Social Security outlay and revenue levels—for both the first fiscal year and (in the House, through fiscal year 1995 only) the sum of all 5 years covered by the budget resolution.	Bill, joint resolution, amendment, motion, or conference report.
313*	In the Senate, prohibits consideration of extraneous provisions in reconciliation legislation (including any special reconciliation legislation triggered by section 258C of the Gramm-Rudman-Hollings Act).	Bill, resolution, amendment, motion, or conference report.
401(a)	Prohibits consideration of legislation providing new contract or borrowing authority not limited to amounts provided in appropriations acts.	Bill, joint resolution, amendment, motion, or conference report.
401(b)(1)	Prohibits consideration of legislation providing new entitlement authority that becomes effective during the fiscal year that ends in the calendar year in which the measure is reported.	Bill, joint resolution, amendment, motion, or conference report.
402(a)	Prohibits consideration of legislation providing new credit authority not limited to amounts provided in appropriations acts.	Bill, joint resolution, amendment, motion, or conference report.
601(b)*	In the Senate, prohibits consideration of a budget resolution for fiscal years 1992–95 or an appropriations measure for fiscal years 1992 or 1993 that would breach the discretionary spending limits, as adjusted, for those years. [Expires after fiscal year 1995.]	Budget resolution, bill, joint resolution, amendment, motion, or conference report.

TABLE 2.—MAJOR POINTS OF ORDER UNDER THE CONGRESSIONAL BUDGET ACT [1]—Continued

Section of the act	Description	Application
605(b)	In the Senate, prohibits consideration of spending or revenue legislation that would cause the GRH deficit target, as adjusted, for the first fiscal year covered by the budget resolution to be exceeded. [Expires after fiscal year 1995.]	Bill, resolution, amendment, motion, or conference report.
606*	Prohibits consideration of a budget resolution that recommends a deficit in excess of the GRH deficit target, as adjusted. In the House, each fiscal year covered by the budget resolution may not exceed the deficit target (section 606(b)). In the Senate, only the first fiscal year covered by the budget resolution may not exceed the deficit target (section 606(c)). [Expires after fiscal year 1995.]	Budget resolution, amendment (in the Senate), or conference report.

---

[1] Sections of the 1974 Budget Act marked with an asterisk (*) require a three-fifths vote of the Senate to waive. With the exception of sections 305(b)(2) and 306, all three-fifths waiver requirements noted in table 1 expire at the end of fiscal year 1995. In general, the Budget Enforcement Act standardized—in sections 904 (c) and (d) of the 1974 Budget Act—the listing of 1974 Budget Act and GRH Act points of order that require a three-fifths vote of the Senate to waive. In a drafting error, section 310(f) of the 1974 Budget Act, which applies only in the House, is among the points of order requiring a three-fifths vote to waive in the Senate, while section 310(g), which prohibits changes in Social Security in reconciliation legislation (and required a three-fifths waiver-vote in the Senate before enactment of the Budget Enforcement Act), is omitted from the listing of three-fifths waivers in sections 904 (c) and (d). In the case of section 310(f), a three-fifths waiver requirement in the Senate has no practical effect. However, in the case of section 310(g), a three-fifths waiver vote in the Senate still is required by virtue of section 271(b) of the GRH Act, which initially established three-fifths waiver requirements for certain Budget Act points of order in 1985 (and is now scheduled to expire after fiscal year 1995).

Source: Congressional Research Service.

THE GRAMM-RUDMAN-HOLLINGS ACT AND THE SEQUESTRATION PROCESS

LEGISLATIVE HISTORY OF THE GRAMM-RUDMAN-HOLLINGS ACT

The Balanced Budget and Emergency Deficit Control Act of 1985, commonly known as the Gramm-Rudman-Hollings (GRH) Act, became law in December of 1985. The GRH Act has been amended several times; the major amendments were made by the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 and the Budget Enforcement Act (BEA) of 1990.

1985 legislation

The GRH Act originated as a Senate amendment to a joint resolution of the House of Representatives (H.J. Res. 372) raising the public debt limit. House and Senate deliberations on the measure occurred in October, November, and December 1985.

The House originated H.J. Res. 372 automatically on August 1, 1985, under procedures contained in House Rule XLIX, when it reached final agreement with the Senate on the first budget resolution for fiscal year 1986. The Senate began consideration of H.J. Res. 372 on October 3 and passed it on October 10 after adopting several amendments dealing with sequestration procedures and other matters. On November 1, the House adopted an amendment offered by Representative Dan Rostenkowski, Chairman of the Ways and Means Committee, thus modifying the measure to include its own version of sequestration procedures. Congressional action on H.J. Res. 372 came to a close on December 11 when the Senate agreed to the conference report by a vote of 61 to 31 and the House agreed by a vote of 271 to 154. President Ronald Reagan signed the measure into law on December 12 (P.L. 99-177; 99 Stat. 1037-1101). The GRH Act constituted title II of Public Law 99-177.

Several lawsuits contesting the constitutionality of the GRH Act were filed immediately. On February 7, 1986, a special three-judge panel of the U.S. district court declared that the procedure for triggering sequestration under the GRH Act was unconstitutional on the ground that it vested executive power in an officer removable by Congress (sequestration would have been triggered pursuant to a report prepared by the Comptroller General, head of the General Accounting Office). Further, the court declared that a sequestration order for fiscal year 1986, issued on February 1, was "without legal force and effect," but stayed its judgment (as required by section 274(e) of the GRH Act) pending appeal to the Supreme Court.

The Supreme Court heard arguments in the case, *Bowsher* v. *Synar*, on April 23 and issued its ruling on July 7. Affirming the ruling of the district court by a vote of 7 to 2, the Supreme Court noted:

> To permit an officer controlled by Congress to execute the laws would be, in essence, to permit a congressional veto. Congress could simply remove, or threaten to remove, an officer for executing the laws in any fashion found to be unsatisfactory to Congress. This kind of congressional control over the execution of the laws, *Chadha* makes clear, is constitutionally impermissible * * *. It is clear that Congress has consistently viewed the Comptroller General as an officer of the Legislative Branch.

Anticipating the possibility of invalidation by the courts, Congress had included "fallback procedures" in the GRH Act under which a presidential sequestration order could be triggered upon the enactment of a joint resolution, reported by the Temporary Joint Committee on Deficit Reduction, setting forth the contents of a joint report of the Office of Management and Budget (OMB) and the Congressional Budget Office (CBO). The Supreme Court stayed its judgment for 60 days in order to allow Congress time to implement sequestration for fiscal year 1986 under the "fallback procedures." Congress subsequently enacted several measures that modified the sequestration process, for the most part exempting programs from the reductions. Most notably, the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) exempted from sequestration the cost-of-living adjustments (COLAs) of all Federal civilian and military retirement and disability programs so that they would be treated in the same manner as Social Security.

1987 legislation

Invalidation by the courts of the automatic triggering mechanism for sequestration and the size of the estimated deficit excess for fiscal year 1988 (more than $50 billion, according to CBO) prompted calls for revision of the GRH Act in the last half of 1987. Major revisions to the GRH Act were enacted in September 1987 as part of a measure (H.J. Res. 324) raising the public debt limit.

The House originated H.J. Res. 324 automatically on June 23, 1987, upon reaching final agreement with the Senate on the first budget resolution for fiscal year 1988. The Senate began its consideration of the measure on July 21 and passed it on July 31, after adopting an amendment revising the sequestration process and amendments on other matters. Conferees met in August and September, filing their report on September 21. The House agreed to the conference report on September 22 by a vote of 230 to 176. On the following day, the Senate agreed to the conference report by a vote of 64 to 34. President Reagan signed the measure into law on September 29 (P.L. 100-119; 101 Stat. 754-788). Title I of Public Law 100-119 is referred to as the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

The 1987 Reaffirmation Act restored the automatic triggering mechanism for sequestration (placing it in the hands of the OMB Director), extended to fiscal year 1993 the timetable for achieving a balanced budget, and made numerous adjustments to the sequestration procedures.

Subsequent to the enactment of Public Law 100-119, Congress enacted several measures that further modified the sequestration process. In particular, the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) made several technical changes in the GRH Act and the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (P.L. 101-73) exempted certain Federal financial entities from sequestration.

1990 legislation

The Budget Enforcement Act of 1990 is title XIII of the Omnibus Budget Reconciliation Act of 1990. Although the BEA was formally developed as part of the 1990 Reconciliation Act, the BEA can be traced to the bipartisan budget summit negotiations between congressional and administration negotiators that began in early May of 1990 and concluded on September 30. On June 26, the President issued a statement that he and congressional negotiators were agreed that any bipartisan budget agreement should include budget process reform "to assure that any bipartisan agreement is enforceable and that the deficit problem is brought under responsible control."

On October 9, the House and Senate reached final agreement on a budget resolution for fiscal year 1991 that embodied in general terms the summit agreement and instructed House and Senate committees to submit deficit reduction legislation under the reconciliation process. In the revised conference report accompanying the budget resolution (H. Rept. 101-820), the conferees expressed their intent "that the reconciliation act implementing this conference agreement include provisions to strengthen the budget process."

On October 15, 1990, the House Budget Committee reported H.R. 5835, the Omnibus Budget Reconciliation Act of 1990 (H. Rept. 101-881), containing the reconciliation recommendations of the instructed House committees. As reported to the House, the bill did not contain a title on budget process changes and the report accompanying the bill did not discuss any changes. The budget process changes, developed by the House leadership, were added by floor amendment on October 16 under a "self-executing" special rule, H. Res. 509 (H. Rept. 101-882); the amendment was added automatically to the bill upon adoption of H.Res. 509. The House considered H.R. 5835 that same day, and after adopting other amendments made in order by the rule, adopted H.R. 5835, as amended, by a vote of 227-203.

Also on October 16, the Senate Budget Committee reported (without written report) S. 3209, the Omnibus Budget Reconciliation Act of 1990, containing the reconciliation recommendations of the instructed Senate committees. The Senate considered S. 3209 on October 17 and 18, adopting with modification an amendment (numbered 3046) offered by Senator George Mitchell, the Majority Leader, which added a budget process title to the bill. Other budget process amendments were separately adopted by the Senate. After completing consideration of S. 3209 on October 18, the Senate by unanimous consent struck the full text of H.R. 5835 and inserted in lieu thereof the language of S. 3209, as amended. The Senate then adopted H.R. 5835, as amended, by a vote of 54-46.

The House, on October 27, approved the conference report (H. Rept. 101-964) by a vote of 228-200. The Senate, later that day, approved the conference report by a vote of 54-45. President George Bush signed H.R. 5835 into law on November 5, 1990.

SUMMARY OF THE SEQUESTRATION PROCESS

Sequestration involves the issuance of a presidential order that permanently cancels budgetary resources (except for special funds and trust funds) for the purpose of achieving a required amount of outlay savings in order to reduce the deficit. The implementation of sequestration reductions is automatic and, therefore, is regarded by many as providing a strong incentive for Congress and the President to reach agreement on legislation meeting the established budgetary goals.

From its inception in late 1985 until its revision by the BEA in late 1990, the process was tied solely to the enforcement of fixed deficit targets. If a sequester of this type occurred, a formula set forth in the GRH Act required that half the required outlay reductions be made in defense programs (programs in the National Defense (050) functional category) and half in nondefense programs. For the most part, sequestration reductions were made uniformly across the range of accounts covered by the process (many accounts, involving roughly two-thirds of Federal outlays, were exempt from sequestration) and were applied uniformly to programs, projects, and activities within accounts. For certain entitlement programs, the reductions were made under special rules (for example, Medicare could not be cut more than 2 percent).

The BEA changed the sequestration process substantially. First, it revised the deficit targets in the GRH Act and extended the sequestration process for 2 more years—through fiscal year 1995 (although the budget is not expected to be in balance by that time). Second, the BEA set limitations on distinct categories of discretionary spending funded in the annual appropriations process. Third, the BEA created pay-as-you-go procedures to require that increases in direct spending (i.e., spending controlled outside of the annual appropriations process) or decreases in revenues due to legislative action are offset so that there is no net effect on the deficit.

In addition to retaining the sequestration process that enforces the deficit targets in the GRH Act, the BEA also established sequestration procedures to enforce the discretionary spending limits and the pay-as-you-go requirements. To the extent that any of the three different types of sequesters must be made, they will occur on the same day (which must be within 15 calendar days after Congress adjourns to end a session); sequestration of this type is referred to informally as "end-of-session sequestration." Further, one or more additional sequesters may occur subsequently in the fiscal year to eliminate any breach in the discretionary spending limits; this type of sequestration is referred to formally as "within-session sequestration."

Sequestration tied to enforcement of the deficit targets would occur only if a deficit excess remained after the other two types of sequestration had been implemented. The operation of the other two types of sequestration will make sequestration tied to the deficit targets impossible through fiscal year 1993.

The deficit targets and discretionary spending limits must be adjusted to take into account a variety of circumstances and developments, as discussed below.

Previously, the surpluses of the Social Security trust funds were included in the deficit estimates made under the GRH Act but Social Security spending (except for administrative expenses) was exempt from sequestration. Under the BEA, Social Security spending still is exempt from sequestration, but the trust fund surpluses are not included in the deficit estimates.

SEQUESTRATION REPORTS AND ORDERS

Under the 1987 Reaffirmation Act, an initial or final sequestration order would be triggered by an initial or revised sequestration report from the Director of OMB. The OMB Director was required to give due regard in his report to a sequestration report issued earlier by the CBO Director, but the CBO Director's report was advisory only. The Comptroller General was not assigned a role in the triggering process; however, he was required to issue a report after sequestration had been completed for a fiscal year assessing compliance with GRH Act requirements.

Under these procedures, sequestration could only be triggered once per fiscal year and any sequestration order issued would remain in effect for that fiscal year only. For programs with cost-of-living adjustments (COLAs), the COLA reductions would last for one year from the time the reduction took place and there would be no catch-up provisions. (COLAs were last reduced in 1986 and are now largely exempt from sequestration.) The process would start all over again to determine whether a sequestration order would be issued for the next fiscal year.

The new, multiple sequestration procedures provided by the BEA remain automatic and are triggered by a report from the OMB Director. However, for sequestration purposes generally, there is only one triggering report issued each year (just after the end of the session). Additionally, OMB reports triggering a sequester in one or more categories of discretionary spending may be issued during the following session if legislative developments so warrant. The CBO Director must continue to provide advisory sequestration reports, five days before the OMB Director's reports are due.

Table 3 sets forth the timetable for the issuance of sequestration reports and orders under current procedures.

Early in the session, OMB and CBO issue sequestration preview reports. The reports provide estimates of the deficit targets and discretionary spending limits, with the adjustments prescribed by law. Also, the reports provide estimates of any net deficit increase or decrease caused by the enactment of direct spending or revenue legislation subject to the pay-as-you-go process. The OMB preview report contains the same information as the CBO preview report and explains any differences between its estimates and those of CBO.

In August, OMB and CBO will issue sequestration update reports to reflect the impact of legislation enacted during the interim. Finally, OMB and CBO will issue final sequestration reports shortly after Congress adjourns to end the session. Both reports will reflect any pertinent legislation enacted since the update reports were issued. The final reports must indicate the baseline amount of budgetary resources and the amount and percentage of the reduction for each account subject to sequestration.

In preparing its update and final sequestration reports, OMB must use the economic and technical assumptions that were used in the earlier preview report. (Previously, OMB could determine in late summer the economic and technical assumptions that it would use for sequestration in October.)

During the course of the session, OMB must provide Congress with cost estimates of budgetary legislation within five days of its enactment, so that compliance with the discretionary spending limits and pay-as-you-go requirements can be monitored. The cost estimates must be based on the economic and technical assumptions used in the President's most recent budget. At the beginning of the 102d Congress, the House adopted a measure (H. Res. 5) that requires direct spending and revenue legislation passed by the House to include cost estimates prepared by CBO and the OMB Director to use these estimates in the preparation of sequestration reports. The Senate has not adopted such a rule.

TABLE 3.—TIMETABLE FOR SEQUESTRATION REPORTS AND ORDERS

Deadline	Action to be completed
5 days before President submits his budget.	CBO issues sequestration preview report.
By first Monday in February..	President submits budget to Congress, including OMB sequestration preview report.
Not later than July 10	CBO issues any required within-session sequestration report regarding discretionary spending.
Not later than July 15	OMB issues any required within-session sequestration report, and President issues sequestration order, regarding discretionary spending.
August 10	President notifies Congress if he intends to exempt military personnel accounts from sequestration.
August 15	CBO issues update report for end-of-session sequestration.
August 20	OMB issues update report for end-of-session sequestration.
10 days after end of session.	CBO issues final report for end-of-session sequestration.
15 days after end of session.	OMB issues final report for end-of-session sequestration; President issues sequestration order, if required.
30 days later	Comptroller General issues GRH Act compliance report.

Several other reports are associated with the sequestration process. First, the CBO Director must issue low-growth reports when certain circumstances are met (see discussion in subsequent section). Second, within-session sequestration reports may be issued by CBO and OMB (no later than July 10 and July 15, respectively) if supplemental appropriations or other discretionary spending is enacted that causes a breach in a discretionary spending limit. Third, the President must notify Congress by August 10 of each year if he intends to use authority provided him in the GRH Act to exempt military personnel accounts from sequestration. Finally, the Comptroller General must issue a compliance report (within 30 days of the issuance of the final OMB sequestration report and the presidential sequestration order) evaluating whether the OMB and CBO reports and the presidential order comply with the requirements of the GRH Act.

DEFICIT TARGETS

The GRH Act initially established a deficit target, referred to as a "maximum deficit amount," for each of 6 fiscal years, beginning with fiscal year 1986. Beginning with fiscal year 1987, the deficit target was reduced by $36 billion each year, leading to a balanced budget in fiscal year 1991. Under the original sequestration procedures, sequestration would not occur for fiscal years 1987–90 if the deficit excess were $10 billion or less (this margin-of-error amount did not apply to fiscal year 1986, in which sequestration was capped at $11.7 billion, nor to fiscal year 1991, when the budget would have to be balanced). In any year in which sequestration occurred, the entire amount of the deficit excess would have to be eliminated.

The 1987 Reaffirmation Act extended the timeframe for the sequestration process by two years (requiring a balanced budget by fiscal year 1993) and revised the deficit targets accordingly. The revised deficit targets maintained the $36 billion year-to-year decrease, except for fiscal year 1989 (when the target was reduced by $8 billion from the prior year) and fiscal year 1993 (when the target was reduced by $28 billion from the prior year). The $10 billion margin-of-error amount was retained for this period, except that sequestration reductions were capped at $23 billion for fiscal year 1988 and $36 billion for fiscal year 1989 and no margin was allowed for fiscal year 1993.

The BEA revised the deficit targets in the GRH Act for fiscal years 1991–95, as shown in table 4. In 1985, the GRH Act set the deficit target for fiscal year 1991 at zero. The fiscal year 1991 target was revised upward to $64 billion in 1987, with the budget expected to be in balance by fiscal year 1993. The BEA revised the fiscal year 1991 target upward to $327 billion. Further, the BEA does not specify a future deficit target of zero; the deficit target for fiscal year 1995, the last fiscal year covered by the procedures, is $117.3 billion (as most recently adjusted). The newly revised deficit targets are greater than the earlier targets because of the change in the treatment of the Social Security trust funds and revised economic and technical assumptions.

TABLE 4.—ORIGINAL AND REVISED DEFICIT TARGETS IN THE GRAMM-RUDMAN-HOLLINGS ACT, AS AMENDED

[Amounts in billions of dollars]

Fiscal year	Original target	1987 revision	1990 revision	Revision in fiscal year 1992 budget
1986	171.9			
1987	144			
1988	108	144		
1989	72	136		
1990	36	100		
1991	0	64	327	
1992		28	317	349.8
1993		0	236	285.2
1994			102	157.5
1995			83	117.3

Note.—The targets were revised in 1990 (by the Budget Enforcement Act of 1990) and in 1991 (as part of the President's budget submission for FY 1992). The targets revised in 1990 and 1991, unlike the targets set in 1985 and revised in 1987, do not reflect the Social Security trust fund surpluses or the Postal Service and are required to be revised in the future under procedures established by the BEA of 1990.

The President is required to adjust the deficit targets for fiscal years 1991–95 (to reflect updated economic and technical assumptions and changes in budgetary concepts and definitions, as applicable), when he submits his annual budget for fiscal years 1992 and 1993. Further, he may adjust the deficit targets for fiscal years 1994 and 1995 (to reflect updated economic and technical assumptions) when he submits his budget for those fiscal years. If the President intends to adjust the deficit targets for fiscal year 1994, he must so notify Congress by January 21, 1993. If he does not adjust the deficit targets for fiscal year 1994, he may not adjust them for fiscal year 1995. For any fiscal year, the deficit targets must be adjusted to take into account changes in the discretionary spending limits made under other procedures. Sequestration reports issued by OMB later in the year must reflect these adjustments.

The BEA retains the sequestration procedures that make across-the-board spending cuts to reduce the deficit down to the target level. The margin-of-error amount (which is the amount by which the deficit target may be exceeded without triggering sequestration) is set at zero for fiscal years 1992 and 1993 and is set at $15 billion for fiscal years 1994 and 1995.

As mentioned previously, sequestration tied to the deficit targets is impossible through fiscal year 1993.

DISCRETIONARY SPENDING LIMITS

The BEA establishes limits on discretionary spending. For fiscal years 1991–93, separate limits are set for new budget authority and outlays for three different categories—defense, international, and domestic. For fiscal years 1994–95, limits on new budget authority and outlays are established for a single category—total discretionary spending. The discretionary spending limits, as most recently adjusted, are shown in table 5.

From fiscal year 1991 to fiscal year 1993, limits on defense budget authority increase by $1.6 billion, limits on international budget authority increase by $1.5 billion, and limits on domestic budget authority increase by $22.9 billion. The increases reflect the growth assumed in the original BEA limits and subsequent adjustments to the limits made under procedures set forth in the BEA (such as adjustments to reflect changes in inflation). About one-third of the increase in the limit on domestic budget authority during this period is attributable to changes in budgetary concepts.

In the President's budget for each of fiscal years 1992–95, discretionary spending limits must be adjusted to take into account changes in budgetary concepts and definitions, changes in inflation, and (for fiscal years 1993–94) changes in estimates of credit subsidy costs.

Additionally, in the final sequestration reports for fiscal years 1991–95 prepared by OMB, discretionary spending limits must be adjusted to allow for Internal Revenue Service (IRS) tax compliance funding, debt forgiveness for Egypt and Poland, International Monetary Fund (IMF) quota increases, emergency appropriations (so designated by the President and by Congress in statute, and including costs for Operation Desert Storm), and specified special allowances. Special budget authority allowances effectively increase the international cap by about $1.2 billion and the domestic cap by about $1.5 billion (precise determinations cannot be made until the aforementioned adjustments are calculated). Special outlay allowances for all three discretionary spending categories are meant to ensure that sequestration will not be triggered due to modest differences in scorekeeping between OMB and CBO.

Enforcement of the spending limits is accomplished through a special sequestration process and by linking the limits to points of order under the Congressional Budget Act. A sequester under this process would occur only within the category in which a breach occurred. If a sequester under this process is required at the end of a session, it must occur on the same day as any sequestration tied to enforcement of the pay-as-you-go procedures or the deficit targets. During the following session, the enactment of legislation causing a breach in the spending limits would trigger sequestration 15 days later; however, any such enactment occurring during the last quarter of the fiscal year (i.e., between July 1 and September 30) would instead cause the appropriate discretionary spending limits for the next fiscal year to be reduced by the amount of the breach.

TABLE 5.—DISCRETIONARY SPENDING LIMITS: FISCAL YEARS 1991–95

[Amounts in billions of dollars]

	1991	1992	1993	1994	1995
Defense:					
Budget authority	289.918	291.361	291.480		
Outlays	298.848	295.800	292.523		
International:					
Budget authority	20.100	20.917	21.643		
Outlays	19.212	19.177	19.802		
Domestic:					
Budget authority	182.891	198.400	205.791		
Outlays	198.863	211.070	223.216		
All Categories:					
Budget authority				518.064	524.976
Outlays				536.521	542.509

Note.—Discretionary spending limits reflect the adjustments made in the OMB final sequestration report for Fiscal Year 1991, issued on November 9, 1990, and in the President's budget for Fiscal Year 1992, submitted to Congress on February 4, 1991; they are subject to further revision in the future under procedures established by the Budget Enforcement Act of 1990.

PAY-AS-YOU-GO (PAYGO) PROCEDURES

Under the 5-year pay-as-you-go (PAYGO) process created by the BEA (which is in effect for fiscal years 1991–95), legislation increasing direct spending or decreasing revenues must be offset so that the deficit is not increased. Direct spending—sometimes referred to as mandatory spending—consists largely of spending for entitlement programs (and the Food Stamp program). Most direct spending and revenue programs are established under permanent law, so there is not necessarily any need for recurring legislative action on them. Enforcement of the PAYGO process is accomplished through a special sequestration procedure and through links to the Congressional Budget Act. The PAYGO process does not preclude Congress from enacting legislation to increase direct spending; it only requires that the increase be offset by reductions in other direct spending programs (which could include increases in fees and other receipts), by increases in revenues, or by a combination of the two.

If a sequester under this process is required, it must occur within 15 calendar days after Congress adjourns at the end of a session and on the same day as any sequestration tied to enforcement of the discretionary spending limits or the deficit targets. The sequester would have to offset the amount of any net deficit increase in that fiscal year and the prior fiscal year caused by the enactment of legislation, and would be applied to non-exempt direct spending programs.

Spending for Social Security benefits and Federal deposit insurance commitments in effect at the time the BEA was enacted, as well as emergency direct spending and revenue legislation (so designated by the President and by Congress in statute) that would cause a deficit increase, is exempted completely from the PAYGO sequestration process. All remaining direct spending programs are covered by the PAYGO process to the extent that legislation affecting their spending levels is counted in determining whether a net increase or decrease in the deficit has occurred for a fiscal year. If a PAYGO sequester occurs, however, many direct spending programs are not subject to reduction. The direct spending programs that may be cut under a PAYGO sequester are listed in table 6.

Under the PAYGO process, the sequester calculations are made so that three programs with automatic spending increases (COLAs)--the National Wool Act, the special milk program, and vocational rehabilitation—are cut first, followed by two special-rule programs (Stafford loans, formerly called guaranteed student loans, and foster care and adoption assistance), and then Medicare and the remaining nonexempt direct programs. The cut in Medicare is limited to 4 percent, rather than 2 percent as in the case of a sequester tied to the deficit targets. According to preliminary sequestration estimates for fiscal year 1992 made by OMB, sequestration reductions of up to $115 million would be taken entirely from the three COLA programs and the two special-rule programs. Further sequestration reductions would be calculated by OMB and CBO under a convention in which reductions are rounded to one-tenth of 1 percent of the applicable spending base. The spending base for programs covered under the PAYGO process is roughly $120 billion. Accordingly, spending excesses up to about $175 million would not necessarily require additional sequestration reductions beyond the five aforementioned programs, thereby sparing Medicare and the remaining nonexempt programs from any cuts.

For instances in which legislation causing a net reduction in revenues is enacted, the House provides a special reconciliation procedure (in section 604 of the Congressional Budget Act) under which the committee of jurisdiction over the enacted legislation would have to report new legislation increasing revenues to offset the deficit increase. The procedure is triggered if the House Budget Committee exercises its option to report a concurrent resolution containing the appropriate reconciliation directives and such resolution is adopted.

SEQUESTRATION ESTIMATES AND CALCULATIONS

Baseline estimates

Under the GRH Act, sequestration reports for a fiscal year must provide baseline estimates of total spending, revenues, the deficit, and the deficit excess for purposes of enforcing the deficit targets; estimates of discretionary spending for purposes of enforcing the discretionary spending limits; and estimates of direct spending, revenues, and the net increase or decrease in the deficit for purposes of enforcing the PAYGO process.

TABLE 6.—DIRECT SPENDING PROGRAMS SUBJECT TO SEQUESTRATION UNDER THE PAY-AS-YOU-GO PROCESS

[Amounts in billions of dollars]

Program	Fiscal year 1992 outlays
Automatic spending increase and special rule programs	0.2
Medicare	98.0
(4-Percent maximum)	(3.9)
Other direct spending programs:	
Commodity Credit Corporation fund	10.3
Social services block grants	2.7
Family support payments to States	1.8
Payments to Japanese internees	0.5
Veterans' education—readjustment benefits	0.5
Payments to States for Mineral Leasing Act	0.4
Agricultural Marketing Service	0.4
Forest Service—cooperative work trust fund	0.3
Rehabilitation services and handicapped research	0.3
Assets forfeiture fund	0.3
Foreign military sales	0.3
Forest Service permanent appropriations	0.2
Medicare (peer review organizations, et cetera)	0.2
Treasury—Customs Service	0.2
Employment Training Administration—Federal unemployment benefits	0.2
Interim assistance to States for legalization	0.1
Veterans' burial benefits and miscellaneous	0.1
Bureau of Land Management—miscellaneous permanent appropriations	0.1
Forest Service—permanent appropriations	0.1
Unemployment trust fund	0.1
Immigration user fee	0.1
Rivers and harbors contributed funds	0.1
Rural electrification and telephone revolving fund	0.1
Agriculture Marketing Service—miscellaneous trust funds	0.1
Sport fish restoration	0.1
Immigration examinations fee	0.1
Black lung trust fund	0.1
Crime victims fund	0.1
Other	1.3
Subtotal	20.9

TABLE 6.—DIRECT SPENDING PROGRAMS SUBJECT TO SEQUESTRATION UNDER THE PAY-AS-YOU-GO PROCESS—Continued

[Amounts in billions of dollars]

Program	Fiscal year 1992 outlays
Spending from offsetting collections:	
Patent and Trademark Office—salaries and expenses	0.3
Lower Colorado River Basin development fund	0.1
United States Mint—salaries and expenses	0.1
Other	0.8
Subtotal	1.2
Total	120.3

The GRH Act prescribes in detail the methodology the OMB and CBO Directors must use in preparing baseline estimates. The Directors must observe the following requirements:

Only enacted law is considered. The Directors do not attempt to anticipate the outcome of legislation still working its way through the legislative process;

The estimates must reflect up-to-date concepts and definitions;

For direct spending and revenues, (1) entitlements are assumed to be fully funded; (2) expiring programs with outlays greater than $50 million are assumed to continue; (3) expiring excise taxes dedicated to a trust fund are assumed to be extended at current rates; (4) the increase for veteran's compensation is assumed to be the same as the increase for veterans' pensions (unless otherwise provided by law enacted in that session); and (5) the receipts and disbursements of the Hospital Insurance Trust Fund are included;

For discretionary spending, the budget authority amounts are those set forth in full-year appropriations acts for the fiscal year. If one or more full-year appropriations have not yet been enacted for the fiscal year, budget authority amounts for the current fiscal year are used, as adjusted for (1) expiring housing contracts, (2) social insurance administrative expenses, (3) offsets regarding pay absorption and pay annualization, (4) inflation, and (5) changes required by law in the level of agency payments for personnel benefits other than pay; and

The receipts and outlays of the Social Security trust funds and the Postal Service are not counted because they are off-budget.

Budgetary Resources and PPAs

Baseline estimates are made on the basis of different categories of budgetary resources. Budgetary resources allow an agency to incur financial obligations and provide the legal authority to sign binding service or procurement contracts, to hire personnel, to make grants, or to make other financial commitments. The most common form of budgetary resources is new budget authority, much of which is provided annually in regular, supplemental, and continuing appropriations acts. Most of the remaining new budget authority is provided automatically each year as permanent appropriations in substantive law.

For defense, budgetary resources subject to sequestration in fiscal years 1992–95 are new budget authority and unobligated balances of prior budget authority. For nondefense programs, budgetary resources subject to sequestration for the same period are new budget authority, direct spending authority, and obligation limitations.

Prior to enactment of the BEA, new direct loans and loan guarantees were subject to sequestration. Their coverage by the sequestration process after fiscal year 1991 was terminated because of reforms in Federal crediting budgeting included in the BEA (and added to the Congressional Budget Act as a new title V). The reforms shift the emphasis to the long-term subsidy element of credit programs and treat the cash flows as a nonbudgetary item (a "means of financing"). The subsidy costs of credit programs generally are subject to sequestration by virtue of their inclusion in the revised definition of budget authority.

Programs with two types of budgetary resource are numerous. For example, the Federal-aid highway program receives new budget authority (in the form of contract authority) and has an obligation limitation. In general, if a program is controlled by both definite budget authority and another budgetary resource, then both budgetary resources are reduced through sequestration.

The GRH Act requires that, in implementing sequestration, the President cut each "program, project, or activity" (PPA) within a budget account by the same percentage. There are single-purpose accounts as well as multipurpose accounts. For example, the Budget lists eight "activities" within the Training and Employment Services account: Block Grant to States; Summer Youth Employment and Training; Dislocated Worker Assistance; Native Americans; Migrants and Seasonal Farmworkers; Job Corps; Veterans' Employment; and National Activities. The GRH Act requires that sequestration reduce each PPA by the same percentage.

The term "program, project, and activity" does not have a statutory definition. Instead, the GRH Act specifies that, for accounts funded through annual appropriations, the term is to be defined each year in appropriation acts and accompanying reports. For accounts not funded by annual appropriations, PPAs are defined by the budget activities listing in the "program and financing table" for each such account in the Budget. For both defense and nondefense accounts, the amounts cut from each PPA are not specified in the sequestration reports.

Calculations

The GRH Act stipulates different methods by which the sequestration calculations are to be made depending on the type of sequester involved. In the course of making these calculations, the OMB and CBO Directors must take into account exemptions and special rules (which are discussed in more detail below).

With regard to sequestration tied to the deficit targets, the GRH Act establishes a formula under which half of the required outlay reductions must be made in defense programs (i.e., programs in the National Defense (050) functional category) and the other half in nondefense programs. Additionally, the Act specifies certain steps that must be followed in calculating the reduction amounts. A deficit sequester would occur only after any sequesters required by the discretionary spending limits or the PAYGO process had been made.

The first step in making the sequestration calculations is to divide the deficit excess in half and assign one of the halves as the required amount of outlay reductions to defense programs and the other half to nondefense programs. In the case of defense programs, the total amount of required outlay reductions for defense programs is divided by the estimated outlays associated with sequesterable budgetary resources for defense, yielding the reduction percentage to be applied uniformly to defense accounts and PPAs.

The calculations for nondefense programs follow a more complicated process. First, the savings from eliminating automatic spending increases (COLAs) for three programs—the National Wool Act, the special milk program, and vocational rehabilitation—are applied to the total amount of required outlay reductions for nondefense programs. Next, the savings to be obtained from certain programs covered under special rules are applied to the amount of required outlay reductions. These programs are Stafford loans (formerly called guaranteed student loans) and foster care and adoption assistance. Finally, the remaining amount of required outlay reductions for nondefense programs is divided by the estimated outlays associated with the remaining sequesterable budgetary resources for nondefense, yielding the reduction percentage to be applied uniformly to nondefense accounts and PPAs. In applying the uniform reductions, cuts in Medicare and certain other health programs are limited to 2 percent. (Because reductions in the Medicare program do not take effect during the first 15 days of the fiscal year, the reduction amount is adjusted in a way that may effectively make it a 2.08 percent reduction.)

With regard to sequestration involving the discretionary spending limits, across-the-board reductions would be made in any category in which the budget authority or outlay limits for that category were breached. A uniform reduction percentage would be calculated for the appropriate category, taking into account whether the President intended to exempt military personnel accounts (in the defense category) and applying the maximum 2-percent reduction in special-rule programs (certain health programs in the domestic category).

In the event that both the budget authority and outlays limits in a category were breached, the sequester would first be calculated to eliminate the budget authority breach. Further reductions would then be made in budgetary resources to eliminate any remaining breach of the outlay limit (after taking the special outlay allowance into account).

The method for making sequester calculations under the PAYGO process is discussed in the preceding section on PAYGO procedures.

Exemptions, special rules, and treatment of administrative expenses

The GRH Act originally exempted from sequestration many specified programs and activities, including Social Security, net interest, certain low-income programs, veterans' compensation and pensions, and regular State unemployment insurance benefits, and certain types of activities, such as offsetting receipts and collections. In addition, the Act also exempted the bases of programs with automatic spending increases subject to sequestration.

Additional exemptions were added by laws enacted in 1986 and 1987, including the Panama Canal Commission Authorization Act, Fiscal Year 1987 (P.L. 99-368), the Insular Areas Regulation Act (P.L. 99-396), the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), the Omnibus Veteran's Benefits Improvement and Health Care Authorization Act of 1986 (P.L. 99-576), the Palau Compact of Free Association Act (P.L. 99-658), and the Competitive Equality Banking Act of 1987 (P.L. 100-86). The 1987 Reaffirmation Act incorporated by specific reference the budget accounts exempted by these laws (except for the Dual Benefits Payments Account and programs exempted by the Competitive Equality Banking Act, which were incorporated at the time of enactment). The 1987 Act also clarified that the Commodity Supplemental Food Program is exempt from sequestration.

Subsequently, the list of exempted programs was modified by enactment of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (P.L. 101-73), the Technical and Correcting Changes in Agriculture Programs Act (P.L. 101-220), and the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). In 1990, the BEA (title XIII of P.L. 101-508) and the Food, Agriculture, Conservation, and Trade Act of 1990 (P.L. 101-624) further modified the list of exempted programs.

Few discretionary spending programs are exempt from sequestration; on the other hand, most direct spending programs are exempt. According to the OMB sequestration preview report for fiscal year 1992, for all direct spending (including Social Security benefits), more than 80 percent of outlays are associated with budgetary resources exempt from sequestration.

Programs exempted from sequestration (or subject to sequestration in a limited fashion under special rules) may be grouped into several categories:

1. *Major programs completely exempt.*—Other than their Federal administrative costs, the following major programs are completely exempt:

Net Interest;
Social Security retirement and disability;
Railroad Retirement Tier I (the Social Security equivalent);
Dual Benefits Payments;
Veterans' Compensation and Pensions;
Federal military and civilian disability and retirement COLA's;
State Unemployment Compensation;
Earned Income Tax Credit;
Selected "Low-Income" programs—AFDC, SSI, Food Stamps, Child Nutrition, WIC, and Medicaid;

Federal power administrations: TVA, BPA, WAPA, SWAPA, SEAPA, and APA;

Postal Service Fund;

Accounts paying claims against the U.S., including Claims, Judgments, and Relief Acts; Defense Claims; Payments to Copyright Owners; Eastern Indian Land Claims; Vietnam and U.S.S. *Pueblo* POW Claims; and Soldiers and Airmen's Home Claims;

Constitutionally protected salaries: Compensation of the President, and Salaries of Article III Judges;

Non-U.S. funds of three types: Foreign Military Sales Trust Fund; activities from private bequests, donations, or voluntary contributions; and appropriations for D.C. (but not the Federal subsidy);

Payments from one Federal account to another, since these do not constitute Federal outlays (primarily, sequestration of these resources can only occur once);

Veterans Insurance, Rehabilitation and Burial Funds;

Certain payments to Panama;

Payments to U.S. Territories;

Payments under the Compact of Free Association;

Farm Credit System Financial Assistance Corporation;

Comptroller of the Currency;

Director of the Office of Thrift Supervision;

Federal Deposit Insurance Corporation (FDIC);

FDIC, Bank Insurance Fund; FDIC, FSLIC Resolution Fund;

FDIC, Savings Association Insurance Fund; Resolution Funding Corporation;

Resolution Trust Corporation;

Federal Savings and Loan Insurance Corporation (FSLIC);

National Credit Union Administration;

Federal Thrift Retirement Board; and

Agricultural Resources Conservation Program.

2. Military personnel accounts.—The GRH Act also authorizes the President to exempt all or some military personnel accounts from sequestration (as long as the total required outlay reductions in defense programs are obtained). This authority, which in the 1985 Act was granted to the President only for fiscal year 1986, was extended by the 1987 Act to fiscal years 1988–93 and by the BEA through fiscal year 1995. It may be exercised only upon timely notification of Congress (on or before August 10). The effect of exercising this authority would be to increase the uniform percentage reduction made in all remaining defense accounts.

3. COLA and special rule programs.—These two types of programs, involving cost-of-living adjustments (COLAs) or special rules that limit the application of a sequester, are described below:

Programs with COLAs, also known as Automatic Spending Increases, may have their COLAs reduced or frozen but their benefit base is protected; that is, the COLAs may not become negative. The programs with automatic spending increases subject to sequestration by the Act as amended are the National Wool Act, special milk program, and vocational rehabilitation programs.

Special rule programs may be cut by specified, limited percentages or amounts. This section describes these special rules.

Stafford Loan Program (formerly Guaranteed Student Loan Program)

The GRH Act requires two changes in the Stafford loan program to occur automatically under sequestration. First, the statutory factor for calculating the special allowances for lenders will be reduced by 0.40 percentage points in the first year of loan. Second, a student's origination fee will increase by 0.50 percentage points. In both cases, sequestration affects only loans made during the applicable fiscal year, but after the order is issued.

Foster Care and Adoption Assistance Programs

The GRH Act limits the amount available for sequester in the foster care and adoption assistance programs to increases in foster care maintenance payment rates or adoption assistance payment rates taking effect during the current fiscal year.

Medicare

The sequestration reductions in the Medicare program are to be achieved by reducing payment amounts for covered services. No changes in co-insurance or deductible obligations are to be made, and covered services are unaffected under a sequestration order. Under such an order, each payment amount would be reduced by a maximum of 2 percent for each year in which there is sequestration tied to the deficit targets or four percent for each year in which there is sequestration under the PAYGO process, relative to whatever level of payment would otherwise be made under Medicare law and regulation. The reduction would be proportionately reduced in any year in which the excess deficit is small enough to permit a smaller reduction.

Veterans' Medical Care and Other Health Programs

The GRH Act limits reductions in budget authority for veterans' medical care, community and migrant health centers, and Indian health services and facilities to 2 percent.

Child Support Enforcement Program

In the child support enforcement (CSE) program, the GRH Act provides that sequestration of entitlement payments to states, including incentive payments from the assistance payments account, is to be accomplished by reducing the federal matching rates for state administrative expenses.

Unemployment Compensation Program

The GRH Act provides that the following items are not available for sequester: regular state unemployment benefits, the State share of extended unemployment benefits, benefits paid to former Federal employees and former members of the armed services, and loans and advances to the State and Federal unemployment accounts. The Federal share of extended benefits, federally paid benefits, including benefits paid under the Railroad Unemployment and Sickness Insurance program, and administrative expenses are available for sequester. The Act also provides that States may, without penalty, reduce their share of Federal-State extended unemployment benefits if the Federal share of benefits is reduced by a sequester order.

Commodity Credit Corporation

The GRH Act requires that payments and loan eligibility under any contract entered into with the Commodity Credit Corporation (CCC) after a sequester order has been issued for a fiscal year be subject to a percentage reduction. The Act requires that reductions for all farm commodities supported by the CCC be made in a uniform manner, including all noncontract programs, projects, and activities within CCC's jurisdiction. The Act further stipulates that outlay reductions in the post-sequester year that are the result of contract adjustments in the sequester year should be credited to the overall outlay reduction required in the sequester year. The actual amount of savings realized in each year will depend upon how the sequester is implemented for the various CCC programs.

Federal pay

The GRH Act provides that rates of pay for civilian employees (and rates of basic pay, basic subsistence allowances, and basic quarter allowances for members of the uniformed services), or any scheduled pay increases, may not be reduced pursuant to a sequestration order. Budgetary resources available for Federal pay, however, will be subject to sequestration as part of the reduction of administrative expenses.

4. *Prior-year outlays and carry-over balances of budget authority from otherwise nonexempt programs.*—For many programs subject to across-the-board sequestration, their prior-year outlays generally are not part of the calculations. More than $100 billion in defense outlays, and a roughly comparable amount in nondefense outlays, are thus excluded from the sequestration calculations. However, new funds for the programs in question are completely available for sequestration.

Specifically, for nondefense programs the GRH Act removes from the calculations all outlays resulting from budgetary resources that were provided in prior fiscal years. Only new budgetary resources are sequesterable, and only the resulting new outlays are included in the calculations.

Many covered programs carry over from one fiscal year to the next obligated or unobligated balances of budget authority. Existing contracts and obligated balances in nondefense and defense programs are exempt from sequestration. With regard to unobligated balances, the exemption applies only to nondefense programs.

5. *Offsetting receipts.*—These receipts are nontax income of the U.S. deposited in the Treasury's General Fund, and are accounted for as "negative spending." An example is the income generated by Outer Continental Shelf Rents and Royalties. The GRH Act exempts such income from sequestration calculations, since sequestration is intended to cut spending, not to increase user fees or speed up auction schedules.

The Act provides that Federal administrative expenses incurred in connection with any program, activity, or account shall be subject to reduction under a sequester order. Any exemption, exception, limitation, or special rule is not intended to include these Federal administrative or operating expenses unless it does so by specific reference.

Under this provision, administrative or operating expenses of all the departments and agencies of the Federal Government, including independent agencies, would be subject to reduction unless specifically exempted. This provision includes programs and agencies that are self-financing and that do not receive appropriations.

The term administrative or operating expenses is intended to include obligations for items such as personnel compensation, travel, transportation, communication, equipment, supplies, materials, and other services and is not intended to include payments, loans, or other benefits resulting from prior legal obligations under the term administrative or operating expenses.

For purposes of this section, payments made by the Federal Government to reimburse or match administrative costs incurred by State or local governments, such as the Federal matching payments for State AFDC, costs for State disability determination units and Medicaid administrative expenses shall not be considered administrative expenses.

SUSPENSION OF THE SEQUESTRATION PROCESS

The 5-year enforcement procedures under the GRH Act and the Congressional Budget Act may be suspended in two ways.

First, the procedures are suspended automatically in the event a declaration of war is enacted. The United States engaged in hostilities with Iraq in early 1991. Although the House and Senate passed a measure in January of 1991, H.J. Res. 77 (P.L. 102-1), authorizing the President to use the United States Armed Forces pursuant to United Nations Security Council Resolution 678 (which pertained to the Iraq/Kuwait crisis), it was not considered to be a formal declaration of war. Representative Thomas Foley, the Speaker of the House, stated that the enactment of a formal declaration of war would have suspended many provisions of law and could have had unwanted domestic effects.

Second, the procedures may be suspended if Congress enacts a special joint resolution triggered by the issuance of a "low-growth" report by CBO. Under this procedure, the CBO director must notify Congress at any time if either of the following two conditions exist: (1) CBO or OMB estimates two consecutive quarters of negative real economic growth during the six-quarter period consisting of the previous quarter, the current quarter, and the four following quarters; or (2) the Commerce Department advance, preliminary or final reports of actual real economic growth for the most recently completed quarter and the preceding quarter indicate economic growth of less than one percent for each quarter. Upon receipt of such a report, the Senate majority leader must introduce (and the House majority leader may introduce) a joint resolution—to be considered under an expedited process—providing for the suspension of the budget enforcement procedures.

On January 23, 1991, Robert Reischauer, the CBO Director, submitted a low-growth report, estimating negative real economic growth for the fourth quarter of 1990 and the first quarter of 1991. Accordingly, Senator George Mitchell, the Senate majority leader, introduced the required joint resolution (S.J. Res. 44) that same day, indicating that he did not favor its enactment at the time. (His statement, the CBO low-growth report, and a letter from Richard Darman, the OMB Director, appear in the Congressional Record of January 23 on pages S 1097–S 1098.) On January 24, the Senate Budget Committee ordered the measure reported unfavorably by a vote of 21–0. The Senate failed to pass S.J.Res. 44 on January 31 by a vote of 2–97. The House majority leader has not exercised his option to introduce such a joint resolution.

A CBO low-growth report is expected to be issued again in April, upon the issuance of the Commerce Department report on actual economic growth for the last quarter of 1990 and the first quarter of 1991.

MODIFICATION OF SEQUESTRATION ORDERS

The GRH Act contains several procedures by which the final sequestration order for a fiscal year may be modified or the implementation of the order affected. Two procedures provide for the modification of a final sequestration order by means of the enactment of a joint resolution considered under expedited procedures.

First, the Majority Leader of the House or Senate may introduce a joint resolution pursuant to section 258A of the Act to modify the end-of-session sequestration order issued by the President, including modifications that effectively cancel it. The joint resolution must be introduced within 20 calendar days of session after the OMB Director has issued the final sequestration report for a fiscal year. The joint resolution, which is considered under expedited procedures, is not referred to committee in either House and is amendable. Because an end-of-session sequester would occur after Congress has adjourned for the session, this procedure could be used only in the following session of Congress.

Second, the President is authorized under section 258B of the Act to submit to Congress a report proposing changes in the reductions in defense programs, projects, and activities (PPAs) made in the end-of-session sequestration order. The President must submit the report within 5 days of the start of the next session of Congress. The changes would increase the amount of reduction for some PPAs in order that the amount of reduction for others could be lessened (or the reduction eliminated altogether). The changes would not occur unless they are affirmed by Congress. Under this procedure, the Majority Leader of the House and Senate must introduce a joint resolution affirming the changes proposed by the President, if the report is timely submitted. Further, the joint resolution must be introduced within 5 session-days after the report is submitted. The joint resolution is referred to the Appropriations Committee of each House, subject to automatic discharge, is considered under expedited procedures, and may be amended.

In exercising this flexibility, the President may not: (1) close or realign any domestic military bases; (2) eliminate any PPA; (3) increase any PPA above the presequester appropriation level; or (4) cause the total level of outlay savings for defense programs to fall below the level required by the final order.

In addition, the GRH Act contains a provision (section 258C) under which the Senate may develop alternatives to a sequestration order by passing legislation under a special reconciliation process (the section does not set forth any House procedures).

Finally, the GRH Act includes a procedure in section 253(f)(2) to ensure that reductions made in appropriations accounts under an end-of-session sequestration order tied to the deficit target are fully achieved. If a partial-year appropriations act (e.g., a short-term continuing resolution) is in effect at the time the order is issued, or if further partial-year appropriations acts are enacted after the order is issued, then the reduction amounts are pro-rated for the period covered by the partial-year act. Pro-rated reductions of partial-year appropriations are withheld but not permanently cancelled.

When a full-year appropriation act (e.g., a regular appropriation act or a full-year continuing resolution) is enacted after a final sequestration order has been issued, the remaining reductions required by the order are made (the budgetary resources are permanently cancelled at this point). Credit toward meeting the sequestration amount is given in cases where the full-year appropriation level is below the baseline amount under the final order. Under the sequestration process, appropriations enacted after a final order may not be reduced as a result of the sequester to a level below the baseline amount minus the sequestration amount.

Due to the timing of the revised sequestration process, in which an end-of-session sequester occurs after Congress has adjourned, the procedures in section 253(f) are not likely to have practical effect.

In addition to employing the procedures in the GRH Act to modify or cancel a final sequestration order, Congress may use its general legislative powers for the same purpose. Congress used omnibus budget reconciliation bills to rescind sequestration reductions for fiscal year 1988 and to modify sequestration reductions for fiscal year 1990 (as discussed in more detail below).

ENFORCEMENT PROCEDURES FOR SOCIAL SECURITY

Transactions of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund (OASDI), commonly referred to as the Social Security trust funds, were excluded from the spending and revenue totals of the Federal Government by the Social Security Amendments Act of 1983 (effective beginning in fiscal year 1993). In 1985, the GRH Act accelerated the removal of the Social Security trust funds, making it effective in fiscal year 1986. Nonetheless, the trust funds—which reflect growing surpluses—were included in the deficit calculations made under the GRH Act for deficit reduction purposes, but were exempt from sequestration (except for administrative expenses).

The Budget Enforcement Act (in sections 12301–13306) reaffirms the off-budget status of Social Security trust funds, excludes them from the deficit and pay-as-you-go calculations made under the GRH Act, and continues their exemption from sequestration.

Because Social Security trust funds are not covered by the enforcement procedures under the GRH Act, the House and Senate have established separate rules that would make it difficult in either chamber to consider legislation that would weaken the financial condition of the program by reducing revenue or increasing spending without offsetting changes.

The House provision creates a point of order (as free-standing law) to prohibit the consideration of legislation that proposes more than $250 million in Social Security spending increases or revenue reductions over 5 years unless offsets are made to keep the net impact within the $250 million limit. Additionally, a point of order would apply to legislation that would increase long-range (75 years) average costs or reduce long-range revenues by at least 0.02 percent of taxable payroll.

The Senate provision also creates a procedure (referred to as a "firewall") to protect Social Security financing, but does so by expanding certain enforcement provisions of the Congressional Budget Act. Under the procedure, the budget resolution must include amounts for Social Security spending and revenues (but these amounts are not included in the budget resolution totals). The Senate provision prohibits the consideration of a reported budget resolution calling for a reduction in Social Security surpluses and bars the consideration of legislation causing committee allocations for Social Security or the aggregate level of Social Security revenues and spending contained in an adopted budget resolution to be exceeded.

SEQUESTRATION ACTIONS FOR FISCAL YEARS 1986-91

The sequestration process has been in effect for the last six fiscal years (fiscal years 1986-91). During this period, sequestration has been triggered four times—for fiscal years 1986, 1988, 1990, and 1991. The sequestration reductions made for fiscal year 1986 were voided by court action and later reaffirmed, the reductions for fiscal year 1988 were later rescinded, the reductions for fiscal year 1990 were modified substantially, and the reductions for fiscal year 1991 were applied only to certain international programs (and may be rescinded in the near future). With regard to the other two fiscal years, sequestration was forestalled for fiscal year 1987 by the enactment of alternative deficit reduction measures and was avoided for fiscal year 1989 because the deficit excess was less than the $10 billion margin-of-error amount.

The deficit excess, as estimated by OMB, has ranged from $9.5 to $83.3 billion, as shown in table 7. Except for fiscal year 1986 (when the deficit estimates were made mid-way through the fiscal year rather than toward its beginning), the difference between the final deficit estimates of OMB and CBO ranged from about $5 billion to $25 billion.

For each fiscal year during this period, the actual deficit exceeded the deficit target in the GRH Act. The overage ranged from about $5 billion for fiscal year 1987 to more than $122 billion for fiscal year 1990.

The sequestration actions for each of the 6 fiscal years is discussed below.

TABLE 7.—SUMMARY OF FINAL DEFICIT ESTIMATES FOR PURPOSES OF SEQUESTRATION: FISCAL YEAR 1986–91

[Amounts in billions of dollars]

Fiscal year	CBO deficit estimate	OMB deficit estimate	Maximum deficit amount	Deficit excess (OMB)	Actual deficit	Estimated outlay savings
1986	220.9	220.1	171.9	48.9	221.6	[1] 11.7
1987	170.6	156.2	144.0	12.2	149.7	[2] None
1988	179.9	164.0	144.0	20.0	155.1	[3] 20.0
1989	151.8	145.5	136.0	9.5	153.4	[4] None
1990	141.3	116.1	100.0	16.1	220.4	[5] 4.6
1991	163.4	147.3	64.0	83.3	NA	([6])

[1] Sequestration for fiscal year 1986 was capped by the GRH Act at $11.7 billion.

[2] Action on a joint resolution to implement sequestration for fiscal year 1987 was not completed because alternative deficit reduction measures were enacted.

[3] Sequestration for fiscal year 1988 was in effect from October 20 until December 22, 1987, when legislation implementing the budget summit agreement of November 20 was enacted. Outlay savings of $20 billion were expected to occur had the sequestration been in effect for the full fiscal year.

[4] The deficit excess for fiscal year 1989 fell within the $10 billion margin-of-error amount.

[5] The deficit excess for fiscal year 1990 was reduced from $16.1 billion to $5.75 billion by section 11002 of the Omnibus Budget Reconciliation Act of 1989 and a new sequestration order, consistent with the lower amount, was issued. CBO estimated that the application of the "crediting" rule under section 252(f) of the GRH Act would reduce the savings from $5.75 billion to $4.55 billion.

[6] Sequestration for fiscal year 1991 was postponed through November 5, 1990, by a series of continuing appropriations acts. On November 5, the President signed the Omnibus Budget Reconciliation Act of 1990 (including the Budget Enforcement Act) into law, changing the sequestration procedures so that a sequester tied to the deficit target no longer was required. A "mini-sequester," affecting only discretionary appropriations for certain international affairs programs, was implemented on November 9; however, this action was caused by a drafting error in the foreign operations appropriations act for fiscal year 1991 and it is expected that the error will be corrected and the sequester rescinded early in the 102d Congress. The actual deficit for fiscal year 1991 is not yet available (NA).

FISCAL YEAR 1986

Because the GRH Act was enacted several months after fiscal year 1986 had begun, sequestration actions for the fiscal year were taken under a truncated schedule. On January 15, 1986, the CBO and OMB Directors submitted a joint "Sequestration Report for Fiscal Year 1986" to the Comptroller General. Differences in their estimates were averaged, resulting in a deficit estimate of $220.5 billion. Although the deficit was estimated to exceed the target of $171.9 billion by $48.6 billion, outlay reductions for the fiscal year were capped by the GRH Act at $11.7 billion. Accordingly, the uniform reduction percentages were 4.9 percent for defense programs (military personnel accounts were exempted) and 4.3 percent for nondefense programs.

In issuing his sequestration report, "Budget Reductions for Fiscal Year 1986," on January 21, the Comptroller General generally agreed with the averaged estimates and calculations made by the CBO and OMB Directors. Consequently, President Reagan issued a sequestration order on February 1.

As previously discussed, rulings by a U.S. district court on February 7 and by the Supreme Court on July 7 invalidated the sequestration order for fiscal year 1986, but the judgments of the courts were stayed to allow Congress to ratify the sequestration order under fallback procedures in the GRH Act.

On July 17, the Temporary Joint Committee on Deficit Reduction reported identical House and Senate joint resolutions aimed at restoring the sequester. The House and Senate acted on a comparable measure (H.J. Res. 672), which passed the House and Senate on July 17 and was signed into law on July 31 (P.L. 99-366).

The actual deficit for fiscal year 1986 amounted to $221.2 billion, almost $50 billion over the deficit target.

FISCAL YEAR 1987

On August 20, 1986, the CBO and OMB Directors submitted their "Initial Sequestration Report for Fiscal Year 1987" to Congress, providing an averaged deficit estimate of $163.4 billion—indicating an excess deficit of $19.4 billion. The Comptroller General, whose role in the triggering of sequestration had been invalidated by the courts, issued an advisory report estimating the deficit at $167.6 billion. Following the Labor Day recess, the House and Senate enacted deficit-reduction legislation (primarily reconciliation and tax reform acts) that brought the deficit down to $151 billion, below the triggering threshold of $154 billion. Accordingly, the Senate rejected (by a vote of 15 to 80) a sequester resolution (S.J. Res. 412) generated under the fallback procedures. The House took no action on the measure.

The actual deficit for fiscal year 1987 amounted to $149.7 billion, almost $5 billion over the deficit target.

FISCAL YEAR 1988

Under the fallback procedures, the CBO and OMB Directors submitted a joint sequestration report for fiscal year 1988 to Congress on August 20, 1987. The averaged deficit estimate of $153.4 billion indicated a deficit excess of $45.4 billion. The House and Senate deferred action on sequester resolutions pending revision of the GRH Act in conjunction with passage of an increase in the debt limit. The revisions in the sequestration process and deficit targets made in September by the 1987 Reaffirmation Act provided that new sequestration actions for fiscal year 1988 be taken under a modified timetable covering October and November.

The CBO and OMB Directors separately issued initial sequestration reports for fiscal year 1988 on October 15 and 20, respectively. The OMB Director estimated the deficit for the fiscal year at $163.0 billion—$19.0 billion above the revised deficit target—and President Reagan issued an initial sequestration order on October 20. The Directors issued revised sequestration reports on November 16 and 20, respectively. Under the revised OMB deficit estimate of $164.0 billion, defense programs (with military personnel accounts exempted) were reduced uniformly by 10.5 percent and nondefense programs by 8.5 percent. President Reagan issued the final sequestration order on November 20.

Negotiators from the House and Senate leadership and the administration, participating in a "budget summit," reached agreement on a compromise plan on November 20. Although the summit agreement came too late to forestall issuance of the final sequestration order, the initial and final sequestration orders were cancelled on December 22 upon the enactment of appropriations and reconciliation implementing the agreement (and budgetary resources that had been sequestered were restored). In total, the compromise plan proposed about $76 billion in savings over 2 years—$30 billion for fiscal year 1988 and $46 billion for fiscal year 1989. According to estimates made by CBO in February 1987, savings in the full-year continuing resolution (P.L. 100-202) and the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) amounted to $34 billion, exceeding the goal set in the summit agreement by about $4 billion.

The actual deficit for fiscal year 1988 amounted to $155.1 billion, more than $11 billion above the deficit target.

FISCAL YEAR 1989

The CBO and OMB Directors issued initial sequestration reports for fiscal year 1989 on August 20 and 25, 1988, respectively. The OMB Director estimated the deficit for the fiscal year at $144.0 billion—$8 billion above the deficit target but $2 billion below the triggering threshold. President Reagan issued an initial sequestration order on August 25 stating that no reductions were necessary at that time. The Directors issued revised sequestration reports on October 10 and 15, respectively. Under the revised OMB deficit estimate of $145.5 billion, the deficit excess fell within the $10 billion margin-of-error amount by $0.5 billion. President Reagan issued a final sequestration order on October 15 declaring that no reductions would be required for fiscal year 1989.

The actual deficit for fiscal year 1989 amounted to $153.4 billion, about $17 billion above the deficit target.

FISCAL YEAR 1990

On August 21, 1989, the CBO and OMB Directors issued initial sequestration reports for fiscal year 1990 (the OMB report was issued several days ahead of the statutory deadline). The OMB Director estimated the deficit at $116.2 billion—$6.2 billion over the triggering threshold. President Bush issued an initial sequestration order on August 25 directing that the reductions in the OMB report be made, effective October 1, on a provisional basis.

The CBO and OMB Directors issued revised sequestration reports on October 10 and 16, respectively. Due to largely offsetting changes in spending, the OMB Director adjusted his deficit estimate by only $0.1 billion, bringing it down to $116.1 billion. On October 16, President Bush issued a final sequestration order adjusting slightly and finalizing the reductions made earlier. In order to eliminate the deficit excess of $16.1 billion, defense programs were cut by 4.3 percent (military personnel accounts were not exempted) and nondefense programs were cut by 5.3 percent.

On December 27, President Bush issued a sequestration order for fiscal year 1990 as required by section 11002 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). The new order, which replaced the order of October 16 issued pursuant to the GRH Act, reduced the estimated outlay savings from sequestration by about two-thirds (to $5.75 billion). Under the "crediting" rule in the

GRH Act, the expected outlay savings under the new order were reduced to $4.55 billion. The modified sequestration reductions, together with other savings in the reconciliation act and other measures, were expected at the time to bring the deficit estimate down to a point below the $110 billion triggering threshold. However, several weeks later (in January 1990) OMB revised the deficit estimate for fiscal year 1990 upward to $122 billion.

The actual deficit for fiscal year 1990 amounted to $220.4 billion, more than $120 billion above the deficit target.

FISCAL YEAR 1991

During most of 1990, while Congress and the President conducted negotiations on the budget for fiscal year 1991, the GRH Act deficit target for the fiscal year was set at $64 billion. Under the sequestration procedures as they existed at that time, President Bush issued initial and final sequestration orders—on August 25 and October 15, respectively—that would have sequestered sufficient budgetary resources to yield the more than $80 billion in outlay savings necessary to meet the $64-billion deficit target. The implementation of the orders, however, was suspended through November 5 by provisions enacted in a series of joint resolutions providing continuing appropriations.

On November 5, the sequestration process was modified substantially when President Bush signed the Omnibus Budget Reconciliation Act (OBRA) of 1990 (containing the BEA of 1990) into law as Public Law 101-508. The enactment of OBRA, which implemented much of the $500 billion in savings over 5 years assumed by the budget resolution, also rescinded the sequestration orders issued on August 25 and October 15.

Under the BEA, the deficit target for fiscal year 1991 was revised upward to $327 billion (the revision reflected updated economic and technical assumptions as well as a different treatment of the Social Security trust funds). The President's budget for fiscal year 1992 (submitted to Congress on February 4, 1991) estimated the deficit for fiscal year 1991 at $318.1 billion, about $9 billion below the target.

On November 9, 1990, President Bush initiated a "mini-sequester" under the BEA in order to reduce a breach of $395 billion in the limit on discretionary budget authority for international programs caused by a drafting error in the Foreign Operations Appropriations Act for Fiscal Year 1991. The mini-sequester required a 1.9 percent uniform reduction in covered international programs. The 102nd Congress is considering legislation (H.J. Res. 157) that would correct the drafting error, cancel the mini-sequester, and restore the sequestered budgetary resources.

THE PRESIDENT'S BUDGETARY PROPOSALS FOR FISCAL YEAR 1992: CONFORMITY TO BUDGET ENFORCEMENT PROCEDURES

The 102d Congress must deal with many different budgetary issues within the procedural framework of the Budget Enforcement Act. Congress must determine whether the original 5-year budget accord requires modification in the face of changing economic conditions and new pressures for spending, and whether budgetary legislation can be developed within the constraints imposed by the Budget Enforcement Act.

The new budget enforcement procedures have replaced the fixed deficit targets with deficit targets and discretionary spending limits that are revised to take into account changes in inflation and other factors beyond Congress' direct control. Under the pay-as-you-go process, spending increases in mandatory programs can occur without violation as long as they are paid for with offsetting spending reductions or revenue increases. Additionally, emergency spending is not constrained by the discretionary spending limits or the pay-as-you-go requirements.

In testimony before the Senate Budget Committee on January 23, 1991, CBO Director Reischauer stated that "like most other forecasters, [CBO] believes that the U.S. economy is now in its ninth recession of the postwar period. This recession should be shorter and milder than the average postwar downturn. CBO expects the recession to end by midyear and to be followed by a period of solid economic growth and significantly reduced inflation. However, * * * this situation is quite uncertain, especially given the situation in the Persian Gulf * * *". A recession typically causes revenues to fall and spending for countercyclical programs, such as unemployment insurance, to increase automatically, thus increasing the deficit.

On February 4, President George Bush submitted to Congress his budget for fiscal year 1992. His budget proposals adhere generally to the overall deficit-reduction goals of the 5-year accord adopted for fiscal years 1991–95. A deficit increase of $7.8 billion over baseline levels is proposed for fiscal year 1991, followed by yearly deficit reductions from the baseline that range between $4.0 billion and $10.8 billion. The total deficit reduction proposed from baseline levels over the 5-year period amounts to just over $20 billion. In addition, baseline deficit levels themselves are estimated by OMB to decline markedly during the last 2 years of this period.

As table 8 shows, the President's budget proposals meet the pay-as-you-go requirements and the discretionary spending limits in each fiscal year during this period (see discussions below regarding fiscal year 1992 proposals). The deficit estimates are made on a consolidated basis (including the surpluses of the Social Security trust funds and spending for the Postal Service).

TABLE 8.—DEFICIT IMPACT OF PRESIDENT'S PROPOSALS: FISCAL YEAR 1991–95

[Amounts in billions of dollars]

	1991	1992	1993	1994	1995
Current services deficit	310.3	284.9	212.3	67.5	12.1
Pay-as-you-go direct spending proposals	−0.1	−6.3	−9.3	−9.0	−11.0
Pay-as-you-go revenue proposals	−0.4	−2.7	−0.4	0.9	1.0
Discretionary proposals (relative to caps)	0	0	−1.5	−0.2	−0.5
Operation Desert Storm	8.2	4.6	0.8	0.4	0
Other changes and debt service	0.1	0.4	−0.2	2.1	1.3
Total deficit impact	7.8	−4.0	−10.8	−5.7	−9.2
Recommended deficit	318.1	280.9	201.5	61.8	2.9

Note.—The deficit estimates are made on a consolidated basis (which includes the surpluses of the Social Security trust funds and spending for the Postal Service).

Source: Budget of the United States Government, fiscal year 1992.

Discretionary spending limits

The President's budget recommendations for fiscal year 1992 (and succeeding fiscal years) meet the discretionary spending limits, as they are expected to be adjusted by the end of the session.

The discretionary spending limits have been adjusted twice so far. First, OMB issued a report on November 9, 1990, "Final OMB Sequester Report to the President and Congress for Fiscal Year 1991" (see H. Doc. 102-11, January 3, 1991), making minor revisions in the discretionary spending limits for fiscal year 1991 following the adjournment sine die of the 101st Congress on October 28, 1990. Second, substantial adjustments were made to the limits in the preview sequestration report for fiscal year 1992 (in part 5 of the President's budget).

Table 9 shows the discretionary spending limits by category as originally enacted, as adjusted in the OMB preview sequestration report, and as they are expected to be adjusted in the OMB final sequestration report issued at the end of the session (referred to as the "EOS estimate"). The table compares the President's request to the EOS estimate. In the case of the defense and international categories, the requests meet or fall slightly below the limits. With regard to domestic spending, the request falls slightly below the outlay limit but more than $2.7 billion below the budget authority limit.

Congress is expected to enact two pending measures providing supplemental appropriations for fiscal year 1991, largely for Operation Desert Storm. The enactment of supplemental appropriations for Operation Desert Storm or supplemental appropriations for designated emergencies will not violate the budget enforcement procedures under the GRH Act. However, a violation-leading to the implementation of a within-session sequester—could occur if nonemergency appropriations are enacted.

TABLE 9.—DISCRETIONARY SPENDING LIMITS AND PRESIDENT'S REQUESTS FOR FISCAL YEAR 1992

[Amounts in billions of dollars]

	Original	Preview	EOS estimate	Request	Request below EOS estimate
Defense:					
Budget authority	291.643	291.361	291.361	291.351	-0.010
Outlays	295.744	295.800	295.800	295.800	0
International:					
Budget authority	20.500	20.917	34.025	34.022	-0.003
Outlays	19.100	19.177	19.613	19.613	0
Domestic:					
Budget authority	191.300	198.400	200.107	197.370	-2.737
Outlays	210.100	211.070	212.053	212.032	-0.021

Note.—"Original" refers to limits set in P.L. 101-508 (November 5, 1990), "preview" refers to limits as adjusted in the President's Fiscal Year 1992 budget, "EOS estimate" refers to estimates of the limits as they are expected to be adjusted at the end of the session, and "request" refers to the amounts recommended by the President in his Fiscal Year 1992 budget.

Pay-As-You-Go Process

The President's budget recommendations for fiscal year 1992 (and succeeding fiscal years) adhere to the pay-as-you-go requirements. The revenue proposals would increase receipts by $2.7 billion and the direct spending proposals would save $6.3 billion, yielding total deficit reduction for fiscal year 1992 under the pay-as-you-go process of $9.0 billion.

APPENDIX Q. EXCERPTS FROM THE CONGRESSIONAL BUDGET AND IMPOUNDMENT CONTROL ACT OF 1974 AND SUBTITLES C AND E OF TITLE XIII OF THE BUDGET ENFORCEMENT ACT OF 1990 AS AMENDED THROUGH DECEMBER 31, 1990

* * * * * * *

DEFINITIONS

SEC. 3. IN GENERAL.—For purposes of this Act—

(1) The terms "budget outlays" and "outlays" mean, with respect to any fiscal year, expenditures and net lending of funds under budget authority during such year.

(2) The term "budget authority" means authority provided by law to enter into obligations which will result in immediate or future outlays involving Government funds or to collect offsetting receipts, except that such term does not include authority to insure or guarantee the repayment of indebtedness incurred by another person or government. The term includes the cost for direct loan and loan guarantee programs, as those terms are defined by title V[1]

(2)[2] BUDGET AUTHORITY AND NEW BUDGET AUTHORITY.—

(A) IN GENERAL.—The term 'budget authority' means the authority provided by Federal law to incur financial obligations, as follows:

(i) provisions of law that make funds available for obligation and expenditure (other than borrowing authority), including the authority to obligate and expend the proceeds of offsetting receipts and collections;

(ii) borrowing authority, which means authority granted to a Federal entity to borrow and obligate and expend the borrowed funds, including through the issuance of promissory notes or other monetary credits;

(iii) contract authority, which means the making of funds available for obligation but not for expenditure; and

(iv) offsetting receipts and collections as negative budget authority, and the reduction thereof as positive budget authority.

(B) LIMITATIONS ON BUDGET AUTHORITY.—With respect to the Federal Hospital Insurance Trust Fund, the Supplementary Medical Insurance Trust Fund, the Unemployment Trust Fund, and the railroad retirement account, any amount that is precluded from obligation in a fiscal year by a provision of law (such as a limitation or a benefit formula) shall not be budget authority in that year.

---

[1] So in law. Probably should have a period. The first sentence of this paragraph applies only through fiscal year 1991.

[2] This paragraph (2) was added by P.L. 101-508, sec. 13211, and is effective for fiscal year 1992 and subsequent fiscal years.

(C) New budget authority.—The term "new budget authority" means, with respect to a fiscal year—

(i) budget authority that first becomes available for obligation in that year, including budget authority that becomes available in that year as a result of a reappropriation; or

(ii) a change in any account in the availability of unobligated balances of budget authority carried over from a prior year, resulting from a provision of law first effective in that year;

and includes a change in the estimated level of new budget authority provided in indefinite amounts by existing law.

(3) The term "tax expenditures" means those revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or a deferral of tax liaiblity, and the term "tax expenditures budget" means an enumeration of such tax expenditures.

(4) The term "concurrent resolution on the budget" means—

(A) a concurrent resolution setting forth the congressional budget for the United States Government for a fiscal year as provided in section 301; and

(B) any other concurrent resolution revising the congressional budget for the United States Government for a fiscal year as described in section 304.

(5) The term "appropriation Act" means an Act referred to in section 105 of title 1, United States Code.

(6) The term "deficit" means, with respect to a fiscal year, the amount by which outlays exceeds receipts during that year.

(7) The term "surplus" means, with respect to a fiscal year, the amount by which receipts exceeds outlays during that year.

(8) The term "government-sponsored enterprise" means a corporate entity created by a law of the United States that—

(A)(i) has a Federal charter authorized by law;

(ii) is privately owned, as evidenced by capital stock owned by private entities or individuals;

(iii) is under the direction of a board of directors, a majority of which is elected by private owners;

(iv) is a financial institution with power to—

(I) make loans or loan guarantees for limited purposes such as to provide credit for specific borrowers or one sector; and

(II) raise funds by borrowing (which does not carry the full faith and credit of the Federal Government) or to guarantee the debt of others in unlimited amounts; and

(B)(i) does not exercise powers that are reserved to the Government as sovereign (such as the power to tax or to regulate interstate commerce);

(ii) does not have the power to commit the Government financially (but it may be a recipient of a loan guarantee commitment made by the Government): and

(iii) has employees whose salaries and expenses are paid by the enterprise and are not Federal employees subject to title 5 of the United States Code.

(9) The term "entitlement authority" means spending authority described by section 401(c)(2)(C).

(10) The term "credit authority" means authority to incur direct loan obligations or to incur primary loans guarantee commitments.

* * * * * * *

TITLE III—CONGRESSONAL BUDGET PROCESS

TIMETABLE

Sec. 300. The timetable with respect to the congressional budget process for any fiscal year is as follows:

On or before:	Action to be completed:
First Monday in February	President submits his budget.
February 15	Congressional Budget Office submits report to Budget Committees.
February 25	Committees submit views and estimates to Budget Committees.[3]
April 1	Senate Budget Committee reports concurrent resolution on the budget.
April 15	Congress completes action on concurrent resolution on the budget.
May 15	Annual appropriation bills may be considered in the House.
June 10	House Appropriations Committee reports last annual appropriation bill.
June 15	Congress completes action on reconciliation legislation.
June 30	House completes action on annual appropriation bills.
October 1	Fiscal year begins.

ANNUAL ADOPTION OF CONCURRENT RESOLUTION ON THE BUDGET

Sec. 301. (a) Content of Concurrent Resolution on the Budget.—On or before April 15 of each year, the Congress shall complete action on a concurrent resolution on the budget for the fiscal year beginning on October 1 of such year. The concurrent resolution shall set forth appropriate levels for the fiscal year beginning on October 1 of such year, and planning levels for each of the two ensuing fiscal years, for the following—

(1) totals of new budget authority, budget outlays, direct loan obligations, and primary loan guarantee commitments;

(2) total Federal revenues and the amount, if any, by which the aggregate level of Federal revenues should be increased or

---

[3] This item should have been amended to reflect the date set forth in section 301(d) which is within 6 weeks after the President submits his budget.

decreased by bills and resolutions to be reported by the appropriate committees;

(3) the surplus or deficit in the budget;

(4) new budget authority, budget outlays, direct loan obligations, and primary loan guarantee commitments for each major functional category, based on allocations of the total levels set forth pursuant to paragraph (1);

(5) the public debt;

(6) For purposes of Senate enforcement under this title, outlays of the old-age, survivors, and disability insurance program established under title II of the Social Security Act for the fiscal year of the resolution and for each of the 4 succeeding fiscal years; and

(7) For purposes of Senate enforcement under this title, revenues of the old-age, survivors, and disability insurance program established under title II of the Social Security Act (and the related provisions of the Internal Revenue Code of 1986) for the fiscal year of the resolution and for each of the 4 succeeding fiscal years.

The concurrent resolution shall not include the outlays and revenue totals of the old age, survivors, and disability insurance program established under title II of the Social Security Act or the related provisions of the Internal Revenue Code of 1986 in the surplus or deficit totals required by this subsection or in any other surplus or deficit total required by this title.

(d) ADDITIONAL MATTERS IN CONCURRENT RESOLUTION.—The concurrent resolution on the budget may—

(1) set forth, if required by subsection (f), the calendar year in which, in the opinion of the Congress, the goals for reducing unemployment set forth in section 4(b) of the Employment Act of 1946 should be achieved;

(2) include reconciliation directives described in section 310;

(3) require a procedure under which all or certain bills or resolutions providing new budget authority or new entitlement authority for such fiscal year shall not be enrolled until the Congress has completed action on any reconciliation bill or reconciliation resolution or both required by such concurrent resolution to be reported in accordance with section 310(b);

(4) set forth such other matters, and require such other procedures, relating to the budget, as may be appropriate to carry out the purposes of this Act;

(5) include a heading entitled "Debt Increase as Measure of Deficit" in which the concurrent resolution shall set forth the amounts by which the debt subject to limit (in section 3101 of title 31 of the United States Code) has increased or would increase in each of the relevant fiscal years;

(6) include a heading entitled "Display of Federal Retirement Trust Fund Balances" in which the concurrent resoluton shall set forth the balances of the Federal retirement trust funds;

(7) set forth pay-as-you-go procedures for the Senate whereby—

(A) budget authority and outlays may be allocated to a committee for legislation that increases funding for entitlement and mandatory spending programs within its jurisdiction if that committee or the committee of conference on such legislation reports such legislation, if, to the extent that the costs of such legislation are not included in the concurrent resolution on the budget, the enactment of such legislation will not increase the deficit (by virtue of either deficit reduction in the bill or previously passed deficit reduction) in the resolution for the first fiscal year covered by the concurrent resolution on the budget, and will not increase the total deficit for the period of fiscal years covered by the concurrent resolution on the budget;

(B) upon the reporting of legislation pursuant to subparagraph (A), and again upon the submission of a conference report on such legislation (if a conference report is submitted), the chairman of the Committee on the Budget of the Senate may file with the Senate appropriately revised allocations under section 302(a) and revised functional levels and aggregates to carry out this paragraph;

(C) such revised allocations, functional levels, and aggregates shall be considered for the purposes of this Act as allocations, functional levels, and aggregates contained in the concurrent resolution on the budget; and

(D) the appropriate committee shall report appropriately revised allocations pursuant to section 302(b) to carry out this paragraph; and

(8) set forth procedures to effectuate pay-as-you-go in the House of Representatives.

* * * * * * *

(d) VIEWS AND ESTIMATES OF OTHER COMMITTEES.—Within 6 weeks after the President submits a budget under section 1105(a) of title 31, United States Code, each committee of the House of Representatives having legislative jurisdiction shall submit to the Committee on the Budget of the House and each committee of the Senate having legislative jurisdiction shall submit to the Committee on the Budget of the Senate its views and estimates (as determined by the committee making such submission) with respect to all matters set forth in subsections (a) and (b) which relate to matters within the jurisdiction or functions of such committee. The Joint Economic Committee shall submit to the Committees on the Budget of both Houses its recommendations as to the fiscal policy appropriate to the goals of the Employment Act of 1946. Any other committee of the House of Representatives or the Senate may submit to the Committee on the Budget of its House, and any joint committee of the Congress may submit to the Committees on the Budget of both Houses, its views and estimates with respect to all matters set forth in subsections (a) and (b) which relate to matters within its jurisdiction or functions.

* * * * * * *

"(i) It shall not be in order in the Senate to consider any concurrent resolution on the budget as reported to the Senate that would decrease the excess of social security revenues over social security outlays in any of the fiscal years covered by the concurrent resolution. No change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.".

COMMITTEE ALLOCATIONS

SEC. 302.[4] (a) ALLOCATION OF TOTALS.—

(1) For the House of Representatives, the joint explanatory statement accompanying a conference report on a concurrent resolution on the budget shall include an estimated allocation, based upon such concurrent resolution as recommended in such conference report, of the appropriate levels of total budget outlays, total new budget authority, and total entitlement authority among each committee of the House of Representatives which has jurisdiction over laws, bills and resolutions providing such new budget authority, or such entitlement authority. The allocation shall, for each committee, divide new budget authority, and entitlement authority between amounts provided or required by law on the date of such conference report (mandatory or uncontrollable amounts), and amounts not so provided or required (discretionary or controllable amounts), and shall make the same division for estimated outlays that would result from such new budget authority.

(2) For the Senate, the joint explanatory statement accompanying a conference report on a concurrent resolution on the budget shall include an estimated allocation, based upon such concurrent resolution as recommended in such conference report, of the appropriate levels of social security outlays for the fiscal year of the resolution and for each of the 4 succeeding fiscal years, total budget outlays and total new budget authority among each committee of the Senate which has jurisdiction over bills and resolutions providing such new budget authority.

* * * * * * *

(f) LEGISLATION SUBJECT TO POINT OF ORDER.—

(1) IN THE HOUSE OF REPRESENTATIVES.—After the Congress has completed action on a concurrent resolution on the budget for a fiscal year, it shall not be in order in the House of Representatives to consider any bill, joint resolution, or amendment providing new budget authority for such fiscal year or new entitlement authority effective during such fiscal year, or any conference report on any such bill or joint resolution, if—

(A) the enactment of such bill or resolution as reported;

(B) the adoption and enactment of such amendment; or

(C) the enactment of such bill or resolution in the form recommended in such conference report,

would cause the appropriate allocation made pursuant to subsection (b) for such fiscal year of new discretionary budget authority or new entitlement authority to be exceeded.

---

[4] All references to credit authority in subsections (a), (b), (c), and (f) have been omitted to reflect the changes made by Public Law 101-508, effective for fiscal years beginning after September 30, 1991.

(2) In the senate.—At any time after the Congress has completed action on the concurrent resolution on the budget required to be reported under section 301(a) for a fiscal year, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report, that provides for budget outlays, new budget authority,[5] or new spending authority (as defined in section 401(c)(2)) in excess of (A) the appropriate allocation of such outlays or authority reported under subsection (a), or (B) the appropriate allocation (if any) of such outlays or authority reported under subsection (b) in connection with the most recently agreed to concurrent resolution on the budget for such fiscal year or provides for social security outlays in excess of the appropriate allocation of social security outlays under subsection (a) for the fiscal year of the resolution or for the total of that year and the 4 succeeding fiscal years. Subparagraph (A) shall not apply to any bill, resolution, amendment, motion, or conference report that is within the jurisdiction of the Committee on Appropriations. In applying this paragraph—

(A) estimated social security outlays shall be deemed to be reduced by the excess of estimated social security revenues (including social security revenues provided for in the bill, resolution, amendment, or conference report with respect to which this paragraph is applied) over the appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget;

(B) estimated social security outlays shall be deemed increased by the shortfall of estimated social security revenues (including social security revenues provided for in the bill, resolution, amendment, or conference report with respect to which this paragraph is applied) below the appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget; and

(C) no provision of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.

The Chairman of the Committee on the Budget of the Senate may file with the Senate appropriately revised allocations under subsection (a) and revised functional levels and aggregates to reflect the application of the preceding sentence. Such revised allocations, functional levels, and aggregates shall be considered as allocations, functional levels, and aggregates contained in the most recently agreed to concurrent resolution on the budget, and the appropriate committees shall report revised allocations pursuant to subsection (b).

* * * * * * *

---

[5] Effective January 1, 1991 and for fiscal year 1991 only insert "or new credit authority" after "new budget authority".

REPORTS, SUMMARIES, AND PROJECTIONS OF CONGRESSIONAL BUDGET ACTIONS

SEC. 308. (a) REPORTS ON LEGISLATION PROVIDING NEW BUDGET AUTHORITY, NEW SPENDING AUTHORITY, OR NEW CREDIT AUTHORITY, OR PROVIDING AN INCREASE OR DECREASE IN REVENUES OR TAX EXPENDITURES.—

(1) Whenever a committee of either House reports to its House a bill or resolution, or committee amendment thereto, providing new budget authority (other than continuing appropriations), new spending authority described in section 401(c)(2), or new credit authority, or providing an increase or decrease in revenues or tax expenditures for a fiscal year (or fiscal years), the report accompanying that bill or resolution shall contain a statement, or the committee shall make available such a statement in the case of an approved committee amendment which is not reported to its House, prepared after consultation with the Director of the Congressional Budget Office—

(A) comparing the levels in such measure to the appropriate allocations in the reports submitted under section 302(b) for the most recently agreed to concurrent resolution on the budget for such fiscal year (or fiscal years);

(B) including an identification of any new spending authority described in section 401(c)(2) which is contained in such measure and a justification for the use of such financing method instead of annual appropriations;

(C) containing a projection by the Congressional Budget Office of how such measure will affect the levels of such budget authority, budget outlays, spending authority, revenues, tax expenditures, direct loan oblgiations, or primary loan guarantee commitments under existing law for such fiscal year (or fiscal years) and each of the four ensuing fiscal years, if timely submitted before such report is filed; and

(D) containing an estimate by the Congressional Budget Office of the level of new budget authority for assistance to State and local governments provided by such measure, if timely submitted before such report is filed.

(2) Whenever a conference report is filed in either House and such conference report or any amendment reported in disagreement or any amendment contained in the joint statement of managers to be proposed by the conferees in the case of technical disagreement on such bill or resolution provides new budget authority (other than continuing appropriations), new spending authority described in section 401(c)(2), or new credit authority, or provides an increase or decrease in revenues for a fiscal year (or fiscal years), the statement of managers accompanying such conference report shall contain the information described in paragraph (1), if available on a timely basis. If such information is not available when the conference report is filed, the committee shall make such information available to

Members as soon as practicable prior to the consideration of such conference report.

* * * * * * *

RECONCILIATION

SEC. 310. (a) INCLUSION OF RECONCILIATION DIRECTIVES IN CONCURRENT RESOLUTIONS ON THE BUDGET.—A concurrent resolution on the budget for any fiscal year, to the extent necessary to effectuate the provisions and requirements of such resolution, shall—

(1) specify the total amount by which—

(A) new budget authority for such fiscal year;

(B) budget authority initially provided for prior fiscal years;

(C) new entitlement authority which is to become effective during such fiscal year; and

(D) credit authority for such fiscal year,

contained in laws, bills, and resolutions within the jurisdiction of a committee is to be changed and direct that committee to determine and recommend changes to accomplish a change of such total amount;

(2) specify the total amount by which revenues are to be changed and direct that the committees having jurisdiction to determine and recommend changes in the revenue laws, bills, and resolutions to accomplish a change of such total amount;

(3) specify the amounts by which the statutory limit on the public debt is to be changed and direct the committee having jurisdiction to recommend such change; or

(4) specify and direct any combination of the matters described in paragraphs (1), (2), and (3) (including a direction to achieve deficit reduction).

(b) LEGISLATIVE PROCEDURE.—If a concurrent resolution containing directives to one or more committees to determine and recommend changes in laws, bills, or resolutions is agreed to in accordance with subsection (a), and—

(1) only one committee of the House or the Senate is directed to determine and recommend changes, that committee shall promptly make such determination and recommendations and report to its House reconciliation legislation containing such recommendations; or

(2) more than one committee of the House or the Senate is directed to determine and recommend changes, each such committee so directed shall promptly make such determination and recommendations and submit such recommendations to the Committee on the Budget of its House, which upon receiving all such recommendations, shall report to its House reconciliation legislation carrying out all such recommendations without any substantive revision.

For purposes of this subsection, a reconciliation resolution is a concurrent resolution directing the Clerk of the House of Representatives or the Secretary of the Senate, as the case may be, to make specified changes in bills and resolutions which have not been enrolled.

(c) COMPLIANCE WITH RECONCILIATION DIRECTIONS.—(1) Any committee of the House of Representatives or the Senate that is directed, pursuant to a concurrent resolution on the budget, to determine and recommend changes of the type described in paragraphs (1) and (2) of subsection (a) with respect to laws within its jurisdiction, shall be deemed to have complied with such directions—

(A) if—

(i) the amount of the changes of the type described in paragraph (1) of such subsection recommended by such committee do not exceed or fall below the amount of the changes such committee was directed by such concurrent resolution to recommend under that paragraph by more than 20 percent of the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection, and

(ii) the amount of the changes of the type described in paragraph (2) of such subsection recommended by such committee do not exceed or fall below the amount of the changes such committee was directed by such concurrent resolution to recommend under that paragraph by more than 20 percent of the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection; and

(B) if the total amount of the changes recommended by such committee is not less than the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection.

(2)(A) Upon the reporting to the Committee on the Budget of the Senate of a recommendation that shall be deemed to have complied with such directions solely by virtue of this subsection, the chairman of that committee may file with the Senate appropriately revised allocations under section 302(a) and revised functional levels and aggregates to carry out this subsection.

(B) Upon the submission to the Senate of a conference report recommending a reconciliation bill or resolution in which a committee shall be deemed to have complied with such directions solely by virtue of this subsection, the chairman of the Committee on the Budget of the Senate may file with the Senate appropriately revised allocations under section 302(a) and revised functional levels and aggregates to carry out this subsection.

(C) Allocations, functional levels, and aggregates revised pursuant to this paragraph shall be considered to be allocations, functional levels, and aggregates contained in the concurrent resolution on the budget pursuant to section 301.

(D) Upon the filing of revised allocations pursuant to this paragraph, the reporting committee shall report revised allocations pursuant to section 302(b) to carry out this subsection.

(d) LIMITATION ON AMENDMENTS TO RECONCILIATION BILLS AND RESOLUTIONS.—

(1) It shall not be in order in the House of Representatives to consider any amendment to a reconciliation bill or reconciliation resolution if such amendment would have the effect of in-

creasing any specific budget outlays above the level of such outlays provided in the bill or resolution (for the fiscal years covered by the reconciliation instructions set forth in the most recentlly agreed to concurrent resolution on the budget), or would have the effect of reducing any specific Federal revenues below the level of such revenues provided in the bill or resolution (for such fiscal years), unless such amendment makes at least an equivalent reduction in other specific budget outlays, an equivalent increase in other specific Federal revenues, or an equivalent combination thereof (for such fiscal years), except that a motion to strike a provision providing new budget authority or new entitlement authority may be in order.

(2) It shall not be in order in the Senate to consider any amendment to a reconciliation bill or reconciliation resolution if such amendment would have the effect of decreasing any specific budget outlay reductions below the level of such outlay reductions provided (for the fiscal years covered) in the reconciliation instructions which relate to such bill or resolution set forth in a resolution providing for reconciliation, or would have the effect of reducing Federal revenue increases below the level of such revenue increases provided (for such fiscal years) in such instructions relating to such bill or resolution, unless such amendment makes a reduction in other specific budget outlays, an increase in other specific Federal revenues, or a combination thereof (for such fiscal years) at least equivalent to any increase in outlays or decrease in revenues provided by such amendment, except that a motion to strike a provision shall always be in order.

(3) Paragraphs (1) and (2) shall not apply if a declaration of war by the Congress is in effect.

(4) For purposes of this section, the levels of budget outlays and Federal revenues for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or of the Senate, as the case may be.

(5) The Committee on Rules of the House of Representatives may make in order amendments to achieve changes specified by reconciliation directives contained in a concurrent resolution on the budget if a committee or committees of the House fail to submit recommended changes to its Committee on the Budget pursuant to its instruction.

(a) PROCEDURE IN THE SENATE.—

(1) Except as provided in paragraph (2), the provisions of section 305 for the consideration in the Senate of concurrent resolutions on the budget and conference reports thereon shall also apply to the consideration in the Senate of reconciliation bills reported under subsection (b) and conference reports thereon.

(2) Debate in the Senate on any reconciliation bill reported under subsection (b), and all amendments thereto and debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours.

(f) COMPLETION OF RECONCILIATION PROCESS.—It shall not be in order in the House of Representatives to consider any resolution providing for an adjournment period of more than three calendar days during the month of July until the House of Representatives has completed action on the reconciliation legislation for the fiscal year beginning on October 1 of the calendar year to which the adjournment resolution pertains, if reconciliation legislation is required to be reported by the concurrent resolution on the budget for such fiscal year.

(g)[6] LIMITATION ON CHANGES TO THE SOCIAL SECURITY ACT.—Notwithstanding any other provision of law, it shall not be in order in the Senate or the House of Representatives to consider any reconciliation bill or reconciliation resolution reported pursuant to a concurrent resolution on the budget agreed to under section 301 or 304, or a joint resolution pursuant to section 258C of the Balanced Budget and Emergency Deficit Control Act of 1985, or any amendment thereto or conference report thereon, that contains recommendations with respect to the old-age, survivors, and disability insurance program established under title II of the Social Security Act.

NEW BUDGET AUTHORITY, NEW SPENDING AUTHORITY, AND REVENUE LEGISLATION MUST BE WITHIN APPROPRIATE LEVELS

SEC. 311. (a)(1) LEGISLATION SUBJECT TO POINT OF ORDER.—Except as provided by subsection (b), after the Congress has completed action on a concurrent resolution on the budget for a fiscal year, it shall not be in order in either the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report providing new budget authority for such fiscal year, providing new entitlement authority effective during such fiscal year, or reducing revenues for such fiscal year, if—

(A) the enactment of such bill or resolution as reported;

(B) the adoption and enactment of such amendment; or

(C) the enactment of such bill or resolution in the form recommended in such conference report;

would cause the appropriate level of total new budget authority or total budget outlays set forth in the most recently agreed to concurrent resolution on the budget for such fiscal year to be exceeded, or would cause revenues to be less than the appropriate level of total revenues set forth in such concurrent resolution except in the case that a declaration of war by the Congress is in effect.

(2)(A) After the Congress has completed action on a concurrent resolution on the budget, it shall not be in order in the Senate to consider any bill, resolution, amendment, motion, or conference report that would cause the appropriate level of total new budget authority or total budget outlays or social security outlays set forth for the first fiscal year in the most recently agreed to concurrent resolution on the budget covering such fiscal year to be exceeded, or would cause revenues to be less than the appropriate level of total revenues (or social security revenues to be less than the appropriate level of social security revenues) set forth for the first fiscal year covered by the resolution and for the period including the first year plus the following 4 years in such concurrent resolution.

---

[6] The requirement in the Senate for three-fifths vote to sustain this point of order expires on September 30, 1995.

(B) In applying this paragraph—

(i)(I) estimated social security outlays shall be deemed to be reduced by the excess of estimated social security revenues (including those provided for in the bill, resolution, amendment, or conference report with respect to which this subsection is applied) over the appropriate level of Social Security revenues specified in the most recently agreed to concurrent resolution on the budget;

(II) estimated social security revenues shall be deemed to be increased to the extent that estimated social security outlays are less (taking into account the effect of the bill, resolution, amendment, or conference report to which this subsection is being applied) than the appropriate level of social security outlays in the most recently agreed to concurrent resolution on the budget; and

(ii)(I) estimated Social Security outlays shall be deemed to be increased by the shortfall of estimated social security revenues (including Social Security revenues provided for in the bill, resolution, amendment, or conference report with respect to which this subsection is applied) below the appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget; and

(II) estimated social security revenues shall be deemed to be reduced by the excess of estimated social security outlays (including social security outlays provided for in the bill, resolution, amendment, or conference report with respect to which this subsection is applied) above the appropriate level of social security outlays specified in the most recently adopted concurrent resolution on the budget; and

(iii) no provision of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.

The chairman of the Committee on the Budget of the Senate may file with the Senate appropriately revised allocations under section 302(a) and revised functional levels and aggregates to reflect the application of the preceding sentence. Such revised allocations, functional levels, and aggregates shall be considered as allocations, functional, levels, and aggregates contained in the most recently agreed to concurrent resolution on the budget, and the appropriate committees shall report revised allocations pursuant to section 302(b).

(b) EXCEPTION IN THE HOUSE OF REPRESENTATIVES.—Subsection (a) shall not apply in the House of Representatives to any bill, resolution, or amendment which provides new budget authority or new entitlement authority effective during such fiscal year, or to any conference report on any such bill or resolution, if—

(1) the enactment of such bill or resolution as reported;

(2) the adoption and enactment of such amendment; or

(3) the enactment of such bill or resolution in the form recommended in such conference report,

would not cause the appropriate allocation of new discretionary budget authority or new entitlement authority made pursuant to section 302(a) for such fiscal year, for the committee within whose jurisdiction such bill, resolution, or amendment falls, to be exceeded.

* * * * * * *

EXTRANEOUS MATTER IN RECONCILIATION LEGISLATION

SEC. 313. (a) IN GENERAL.—When the Senate is considering a reconciliation bill or a reconciliation resolution pursuant to section 310 (whether that bill or resolution originated in the Senate or the House) or section 258C of the Balanced Budget and Emergency Deficit Control Act of 1985, upon a point of order being made by any Senator against material extraneous to the instructions to a committee which is contained in any title or provision of the bill or resolution or offered as an amendment to the bill or resolution, and the point of order is sustained by the Chair, any part of said title or provision that contains material extraneous to the instructions to said Committee as defined in subsection (b) shall be deemed stricken from the bill and may not be offered as an amendment from the floor.

(b) EXTRANEOUS PROVISIONS.—(1)(A) Except as provided in paragraph (2), a provision of a reconciliation bill or reconciliation resolution considered pursuant to section 310 shall be considered extraneous if such provision does not produce a change in outlays or revenue, including changes in outlays and revenues brought about by changes in the terms and conditions under which outlays are made or revenues are required to be collected (but a provision in which outlays decreases or revenue increases exactly offset outlay increases or revenue decreases shall not be considered extraneous by virtue of this subparagraph); (B) any provision producing an increase in outlays or decrease in revenues shall be considered extraneous if the net effect of provisions reported by the Committee reporting the title containing the provision is that the Committee fails to achieve its reconciliation instructions; (C) a provision that is not in the jurisdiction of the Committee with jurisdiction over said title or provision shall be considered extraneous; (D) a provision shall be considered extraneous if it produces changes in outlays or revenues which are merely incidental to the non-budgetary components of the provision; (E) a provision shall be considered to be extraneous if it increases, or would increase, net outlays, or if it decreases, or would decrease, revenues during a fiscal year after the fiscal years covered by such reconciliation bill or reconciliation resolution, and such increases or decreases are greater than outlay reductions or revenue increases resulting from other provisions in such title in such year; and (F) a provision shall be considered extraneous if it violates section 310(g).

(2) A Senate-originated provision shall not be considered extraneous under paragraph (1)(A) if the Chairman and Ranking Minority Member of the Committee on the Budget and the Chairman and Ranking Minority Member of the Committee which reported the

provision certify that: (A) the provision mitigates direct effects clearly attributable to a provision changing outlays or revenue and both provisions together produce a net reduction in the deficit; (B) the provision will result in a substantial reduction in outlays or a substantial increase in revenues during fiscal years after the fiscal years covered by the reconciliation bill or reconciliation resolution; (C) a reduction of outlays or an increase in revenues is likely to occur as a result of the provision, in the event of new regulations authorized by the provision or likely to be proposed, court rulings on pending litigation, or relationships between economic indices and stipulated statutory triggers pertaining to the provision, other than the regulations, court rulings or relationships currently projected by the Congressional Budget Office for scorekeeping purposes; or (D) such provision will be likely to produce a significant reduction in outlays or increase in revenues but, due to insufficient data, such reduction or increase cannot be reliably estimated.

(3) A provision reported by a committee shall not be considered extraneous under paragraph (1)(C) if (A) the provision is an integral part of a provision or title, which if introduced as a bill or resolution would be referred to such committee, and the provision sets forth the procedure to carry out or implement the substantive provisions that were reported and which fall within the jurisdiction of such committe; or (B) the provision states an exception to, or a special application of, the general provision or title of which it is a part and such general provision or title if introduced as a bill or resolution would referred to such committee.

(c) EXTRANEOUS MATERIALS.—Upon the reporting or discharge of a reconciliation bill or resolution pursuant to section 310 in the Senate, and again upon the submission of a conference report on such a reconciliation bill or resolution, the Committee on the Budget of the Senate shall submit for the record a list of material considered to be extraneous under subsections (b)(1)(A), (b)(1)(B), and (b)(1)(E) of this section to the instructions of a committee as provided in this section. The inclusion or exclusion of a provision shall not constitute a determination of extraneousness by the Presiding Officer of the Senate.

(c)[7] When the Senate is considering a conference report on, or an amendment between the Houses in relation to, a reconciliation bill or reconciliation resolution pursuant to section 310, upon—

(1) a point of order being made by any Senator against extraneous material meeting the definition of subsections (b)(1)(A), (b)(1)(B), (b)(1)(D), (b)(1)(E), or (b)(1)(F), and

(2) such point of order being sustained,

such material contained in such conference report or amendment shall be deemed stricken, and the Senate shall proceed, without intervening action or motion, to consider the question of whether the Senate shall recede from its amendment and concur with a further amendment, or concur in the House amendment with a further amendment, as the case may be, which further amendment shall consist of only that portion of the conference report or House amendment, as the case may be, not so stricken. Any such motion in the Senate shall be debatable for two hours. In any case in which such point of order is sustained against a conference report (or Senate amendment derived from such conference report by operation of this subsection), no further amendment shall be in order.

---

[7] Section 13214(b) (2) and (3) of P.L. 101-508 inadvertently created two subsection (c)'s.

(d) General Point of Order.—Notwithstanding any other law or rule of the Senate, it shall be in order for a Senator to raise a single point of order that several provisions of a bill, resolution, amendment, motion, or conference report violate this section. The Presiding Officer may sustain the point of order as to some or all of the provisions against which the Senator raised the point of order. If the Presiding Officer so sustains the point of order as to some of the privisions (including provisions of an amendment, motion, or conference report) against which the Senator raised the point of order, then only those provisions (including provisions of an amendment, motion, or conference report) against which the Presiding Officer sustains the point of order shall be deemed stricken pursuant to this section. Before the Presiding Officer rules on such a point of order, any Senator may move to waive such a point of order as it applies to some or all of the provisions against which the point of order was raised. Such a motion to waive is amendable in accordance with the rules and precedents of the Senate. After the Presiding Officer rules on such a point of order, any Senator may appeal the ruling of the Presiding Officer on such a point of order as it applies to some or all of the provisions on which the Presiding Officer ruled.

(e) Determination of Levels.—For purposes of this section, the levels of new budget authority, budget outlays, new entitlement authority, and revenues for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the Senate.

TITLE IV—ADDITIONAL PROVISIONS TO IMPROVE FISCAL PROCEDURES

BILLS PROVIDING NEW SPENDING AUTHORITY

Sec. 401. (a) Controls on Legislation Providing Spending Authority.—It shall not be in order in either the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report, as reported to its House which provides new spending authority described in subsection (c)(2) (A) or (B), unless that bill, resolution, conference report, or amendment also provides that such new spending authority as described in subsection (c)(2) (A) or (B) is to be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

(b) Legislation Providing Entitlement Authority.—

(1) It shall not be in order in either the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report, as reported to its House which provides new spending authority described in subsection (c)(2)(C) which is to become effective before the first day of the fiscal year which begins during the calendar year in which such bill or resolution is reported.

(2) If any committee of the House of Representatives or the Senate reports any bill or resolution which provides new spending authority described in subsection (c)(2)(C) which is to become effective during a fiscal year and the amount of new budget authority which will be required for such fiscal year if such bill or resolution is enacted as so reported exceeds the appropriate allocation of new budget authority reported under section 302(b) in connection with the most recently agreed to concurrent resolution on the budget for such fiscal year, such bill or resolution shall then be referred to the Committee on Appropriations of that House with instructions to report it, with the committee's recommendatons, within 15 calendar days (not counting any day on which that House is not in session) beginning with the day following the day on which it is so referred. If the Committee on Appropriations of either House fails to report a bill or resolution referred to it under this paragraph within such 15-day period, the committee shall automatically be discharged from further consideration of such bill or resolution and such bill or resolution shall be placed on the appropriate calendar.

(3) The Committee on Appropriations of each House shall have jurisdiction to report any bill or resolution referred to it under paragraph (2) with an amendment which limits the total amount of new spending authority provided in such bill or resolution.

(c) DEFINITIONS.—

(1) For purposes of this section, the term "new spending authority" means spending authority not provided by law on the effective date of this Act, including any increase in or addition to spending authority provided by law on such date.

(2) For purposes of paragraph (1), the term "spending authority" means authority (whether temporary or permament)—

(A) to enter into contracts under which the United States is obligated to make outlays, the budget authority for which is not provided in advance by appropriation Acts;

(B) to incur indebtedness (other than indebtedness incurred under chapter 31 of title 31 of the United States Code) for the repayment of which the United States is liable, the budget authority for which is not provided in advance by appropriation Acts;

(C) to make payments (including loans and grants), the budget authority for which is not provided for in advance by appropriation Acts, to any person or government if, under the provisions of the law containing such authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by such law;

(D) to forego the collection by the United States of proprietary offsetting receipts, the budget authority for which is not provided in advance by appropriation Acts to offset such foregone receipts; and

(E) to make payments by the United States (including loans, grants, and payments from revolving funds) other than those covered by subparagraph (A), (B), (C), or (D), the budget authority for which is not provided in advance by appropriation Acts.

Such term does not include authority to insure or guarantee the repayment of indebtedness incurred by another person or government.

(d) Exceptions.—

(1) Subsections (a) and (b) shall not apply to new spending authority if the budget authority for outlays which will result from such new spending authority is derived—

(A) from a trust fund established by the Social Security Act (as in effect on the date of the enactment of this Act); or

(B) from any other trust fund, 90 percent or more of the receipts of which consist or will consist of amounts (transferred from the general fund of the Treasury) equivalent to amounts of taxes (related to the purposes for which such outlays are or will be made) received in the Treasury under specified provisions of the Internal Revenue Code of 1954.

(2) Subsections (a) and (b) shall not apply to new spending authority which is an amendment to or extension of the State and Local Fiscal Assistance Act of 1972, or a continuation of the program of fiscal assistance to State and local governments provided by that Act, to the extent so provided in the bill or resolution providing such authority.

(3) Subsections (a) and (b) shall not apply to new spending authority to the extent that—

(A) the outlays resulting therefrom are made by an organization which is (i) a mixed-ownership Government corporation (as defined in section 201 of the Government Corporation Control Act), or (ii) a wholly owned Government corporation (as defined in section 101 of such Act) which is specifically exempted by law from compliance with any or all of the provisions of that Act, as of the date of enactment of the Balanced Budget and Emergency Deficit Control Act of 1985; or

(B) the outlays resulting therefrom consist exlusively of the proceeds of gifts or bequests made to the United States for a specific purpose.

* * * * * * *

TITLE VI—BUDGET AGREEMENT ENFORCEMENT PROVISIONS[8]

SEC. 601. DEFINITIONS AND POINT OF ORDER.

(a) Definitions.—As used in this title and for purposes of the Balanced Budget and Emergency Deficit Control Act of 1985:

(1) Maximum deficit amount.—The term "maximum deficit amount" means—

(A) with respect to fiscal year 1991, $327,000,000,000;

---

[8] This title applies only to fiscal years 1991 to 1995. See section 607.

(B) with respect to fiscal year 1992, $317,000,000,000;
(C) with respect to fiscal year 1993, $236,000,000,000;
(D) with respect to fiscal year 1994, $102,000,000,000; and
(E) with respect to fiscal year 1995, $83,000,000,000;

as adjusted in strict conformance with sections 251, 252, and 253 of the Balanced Budget and Emergency Deficit Control Act of 1985.

(2) DISCRETIONARY SPENDING LIMIT.—The term "discretionary spending limit" means—

(A) with respect to fiscal year 1991—

(i) for the defense category: $288,918,000,000 in new budget authority and $297,660,000,000 in outlays;

(ii) for the international category: $20,100,000,000 in new budget authority and $18,600,000,000 in outlays; and

(iii) for the domestic category: $182,700,000,000 in new budget authority and $198,100,000,000 in outlays;

(B) with respect to fiscal year 1992—

(i) for the defense category: $291,643,000,000 in new budget authority and $295,744,000,000 in outlays;

(ii) for the international category: $20,500,000,000 in new budget authorty and $19,100,000,000 in outlays; and

(iii) for the domestic category: $191,300,000,000 in new budget authority and $210,100,000,000 in outlays;

(C) with respect to fiscal year 1993—

(i) for the defense category: $291,785,000,000 in new budget authority and $292,686,000,000 in outlays;

(ii) for the international category: $21,400,000,000 in new budget authority and $19,600,000,000 in outlays; and

(iii) for the domestic category: $198,300,000,000 in new budget authority and $221,700,000,000 in outlays;

(D) with respect to fiscal year 1994, for the discretionary category: $510,800,000,000 in new budget authority and $534,800,000,000 in outlays; and

(E) with respect to fiscal year 1995, for the discretionary category: $517,700,000,000 in new budget authority and $540,800,000,000 in outlays;

as adjusted in strict conformance with section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985.

(b) [9]POINT OF ORDER IN THE SENATE ON AGGREGATE ALLOCATIONS FOR DEFENSE, INTERNATIONAL, AND DOMESTIC DISCRETIONARY SPENDING.—

(1) Except as provided in paragraph (3), it shall not be in order in the Senate to consider any concurrent resolution on the budget for fiscal year 1992, 1993, 1994, or 1995 (or amendment, motion, or conference report on such a resolution), or any appropriations bill or resolution (or amendment, motion, or conference report on such an appropriations bill or resolution) for fiscal year 1992 or 1993 that would exceed the alloca-

---

[9] So in law. Paragraphs (3) and (4) should be redesignated as (2) and (3), respectively.

tions in this section or the suballocations made under section 602(b) based on these allocations.

(3) For purposes of this subsection, the levels of new budget authority and outlays for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the Senate.

(4) This subsection shall not apply if a declaration of war by the Congress is in effect or if a joint resolution pursuant to section 258 of the Balanced Budget and Emergency Deficit Control Act of 1985 has been enacted.

SEC. 602. COMMITTEE ALLOCATIONS AND ENFORCEMENT.

(a) Committee Spending Allocations.—

(1) House of Representatives.—

(A) Allocation among committees.—The joint explanatory statement accompanying a conference report on a budget resolution shall include allocations, consistent with the resolution recommended in the conference report, of the appropriate levels (for each fiscal year covered by that resolution and a total for all such years) of—

(i) total new budget authority,

(ii) total entitlement authority, and

(iii) total outlays;

among each committee of the House of Representatives that has jurisdiction over legislation providing or creating such amounts.

(B) No double counting.—Any item allocated to one committee of the House of Representatives may not be allocated to another such committee.

(C) Further division of amounts.—The amounts allocated to each committee for each fiscal year, other than the Committee on Appropriations, shall be further divided between amounts provided or required by law on the date of filing of that conference report and amounts not so provided or required. The amounts allocated to the Committee on Appropriations for each fiscal year shall be further divided between discretionary and mandatory amounts or programs, as appropriate.

(2) Senate allocation among committees.—The joint explanatory statement accompanying a conference report on a budget resolution shall include an allocation, consistent with the resolution recommended in the conference report, of the appropriate levels of—

(A) total new budget authority;

(B) total outlays; and

(C) social security outlays;

among each committee of the Senate that has jurisdiction over legislation providing or creating such amounts.

(3) Amounts not allocated.—(A) In the House of Representatives, if a committee receives no allocation of new budget authority, entitlement authority, or outlays, that committee shall be deemed to have received an allocation equal to zero for new budget authority, entitlement authority, or outlays.

(B) In the Senate, if a committee receives no allocation of new budget authority, outlays, or social security outlays, that committee shall be deemed to have received an allocation equal to zero for new budget authority, outlays, or social security outlays.

(b) SUBALLOCATIONS BY COMMITTEES.—

(1) SUBALLOCATIONS BY APPROPRIATIONS COMMITTEES.—As soon as practicable after a budget resolution is agreed to, the Committee on Appropriations of each House (after consulting with the Committee on Appropriations of the other House) shall suballocate each amount allocated to it for the budget year under subsection (a)(1)(A) or (a)(2) among its subcommittees. Each Committee on Appropriations shall promptly report to its House suballocations made or revised under this paragraph.

(2) SUBALLOCATIONS BY OTHER COMMITTEES OF THE SENATE.—Each other committee of the Senate to which an allocation under subsection (a)(2) is made in the joint explanatory statement may subdivide each amount allocated to it under subsection (a) among its subcommittees or among programs over which it has jurisdiction and shall promptly report any such suballocations to the Senate. Section 302(c) shall not apply in the Senate to committees other than the Committee on Appropriations.

(c) APPLICATION OF SECTION 302(f) TO THIS SECTION.—In fiscal years through 1995, reference in section 302(f) to the appropriate allocation made pursuant to section 302(b) for a fiscal year shall, for purposes of this section, be deemed to be a reference to any allocation made under subsection (a) or any suballocation made under subsection (b), as applicable, for the fiscal year of the resolution or for the total of all fiscal years made by the joint explanatory statement accompanying the applicable concurrent resolution on the budget. In the House of Representatives, the preceding sentence shall not apply with respect to fiscal year 1991.

(d) APPLICATION OF SUBSECTION (a) AND (b) TO FISCAL YEARS 1992 TO 1995.—In the case of concurrent resolutions on the budget for fiscal years 1992 through 1995, allocations shall be made under subsection (a) instead of section 302(a) and shall be made under subsection (b) instead of section 302(b). For those fiscal years, all references in sections 302(c), (d), (e), (f), and (g) to section 302(a) shall be deemed to be to subsection (a) (including revisions made under section 604) and all such references to section 302(b) shall be deemed to be to subsection (b) (including revisions made under section 604).

(e) PAY-AS-YOU-GO EXCEPTION IN THE HOUSE.—[10] Section 302(f)(1) and, after April 15 of any calendar year section 303(a), shall not apply to any bill, joint resolution, amendment thereto, or conference report thereon if, for each fiscal year covered by the most recently agreed to concurrent resolution on the budget—

(1) the enactment of such bill or resolution as reported;

(2) the adoption and enactment of such amendment; or

---

[10] So in law. "(1)" should have been inserted here and paragraphs (1), (2), and (3) should have been redesignated as subparagraphs (A), (B), and (C).

(3) the enactment of such bill or resolution in the form recommended in such conference report,

would not increase the deficit for any such fiscal year, and, if the sum of any revenue increases provided in legislation already enacted during the current session (when added to revenue increases, if any, in excess of any outlay increase provided by the legislation proposed for consideration) is at least as great as the sum of the amount, if any, by which the aggregate level of Federal revenues should be increased as set forth in that concurrent resolution and the amount, if any, by which revenues are to be increased pursuant to pay-as-you-go procedures under section 301(b)(8) if included in that concurrent resolution.

(2) REVISED ALLOCATIONS.—

(A) As soon as practicable after Congress agrees to a bill or joint resolution that would have been subject to a point of order under section 302(f)(1) but for the exception provided in paragraph (1), the chairman of the Committee on the Budget of the House of Representatives may file with the House appropriately revised allocations under section 302(a) and revised functional levels and budget aggregates to reflect that bill.

(B) such revised allocations, functional levels, and budget aggregates shall be considered for the purposes of this Act as allocations, functional levels, and budget aggregates contained in the most recently agreed to concurrent resolution on the budget.

SEC. 603. CONSIDERATION OF LEGISLATION BEFORE ADOPTION OF BUDGET RESOLUTION FOR THAT FISCAL YEAR

(a) ADJUSTING SECTION ALLOCATION OF DISCRETIONARY SPENDING.—If a concurrent resolution on the budget is not adopted by April 15, the chairman of the Committee on the Budget of the House of Represenatives shall submit to the House, as soon as practicable, a section 602(a) allocation to the Committee on Appropriations consistent with the discretionary spending limits contained in the most recent budget submitted by the President under section 1105(a) of title 31, United States Code. Such allocation shall include the full allowance specified under section 251(b)(2)(E)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

(b) As soon as practicable after a section 602(a) allocation is submitted under this section, the Committee on Appropriations shall make suballocations and promptly report those suballocations to the House of Represenatives.

SEC. 604. RECONCILIATION DIRECTIVES REGARDING PAY-AS-YOU-GO REQUIREMENTS.

(a) INSTRUCTIONS TO EFFECTUATE PAY-AS-YOU-GO IN THE HOUSE OF REPRESENTATIVES.—If legislation providing for a net reduction in revenues in any fiscal year (that, within the same measure, is not fully offset in that fiscal year by reductions in direct spending) is enacted, the Committee on the Budget of the House of Representatives may report, within 15 legislative days during a Congress, a pay-as-you-go reconciliation directive in the form of a concurrent resolution—

(1) specifying the total amount by which revenues sufficient to eliminate the net defict increase resulting from that legislation in each fiscal year are to be changed; and

(2) directing that the committee having jurisdiction determine and recommend changes in the revenue law, bills, and resolutions to accomplish a change of such total amount.

(b) CONSIDERATION OF PAY-AS-YOU-GO RECONCILIATION LEGISLATION IN THE HOUSE OF REPRESENTATIVES.— In the House of Representatives, subsections (b) through (d) of section 310 shall apply in the same manner as if the reconciliation directive decribed in subsection (a) were a concurrent resolution on the budget.

SEC. 605. APPLICATION OF SECTION 311; POINT OF ORDER.

(a) APPLICATION OF SECTION 311(a).—(1) In the House of Representatives, in the application of section 311(a)(1) to any bill, resolution, amendment, or conference report, reference in section 311 to the appropriate level of total budget authority or total budget outlays or appropriate level of total revenues set forth in the most recently agreed to concurrent resolution on the budget for a fiscal year shall be deemed to be a reference to the appropriate level for that fiscal year and to the total of the appropriate level for that year and the 4 succeeding years.

(2) In the Senate, in the application of section 311(a)(2) to any bill, resolution, motion, or conference report, reference in section 311 to the appropriate level of total revenues set forth in the most recently agreed to concurrent resolution on the budget for a fiscal year shall be deemed to be a reference to the appropriate level for that fisal year and to the total of the appropriate levels for that year and the 4 succeeding years.

(b) MAXIMUM DEFICIT AMOUNT POINT OF ORDER IN THE SENATE.—After Congress has completed action on a concurrent resolution on the budget, it shall not be in order in the Senate to consider any bill, resolution, amendment, motion, or conference report that would result in a deficit for the first fiscal year covered by that resolution that exceeds the maximum deficit amount specified for such fiscal year in section 601(a).

SEC. 606. 5-YEAR BUDGET RESOLUTIONS; BUDGET RESOLUTIONS MUST CONFORM TO BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985.

(a) 5-YEAR BUDGET RESOLUTIONS.—In the case of any concurrent resolution on the budget for fiscal year 1992, 1993, 1994, or 1995, that resolution shall set forth appropriate levels for the fiscal year beginning on October 1 of the calendar year in which it is reported and for each of the 4 succeeding fiscal years for the matters described in section 301(a).

(B) POINT OF ORDER IN THE HOUSE OF REPRESENTATIVES.—It shall not be in order in the House of Representatives to consider any concurrent resolution on the budget for a fiscal year or conference report thereon under section 301 or 304 that exceeds the maximum deficit amount for each fiscal year covered by the concurrent resolution or conference report as determined under section 601(A), including possible revisions under part C of the Balanced Budget and Emergency Deficit Control Act of 1985.

(c) Point of Order in the Senate.—It shall not be in order in the Senate to consider any concurrent resolution on the budget for a fiscal year under section 301, or to consier any amendment to such a concurrent resolution, or to consider a conference report on such a concurrent resolution, if the level of total budget outlays for the first fiscal year that is set forth in such concurrent resolution or conference report exceeds the recommended level of Federal revenues set forth that year by an amount that is greater than the maximum deficit amount for such fiscal year as determined under section 601(a), or if the adoption of such amendment would result in a level of total budget outlays for that fiscal year which exceeds the recommended level of Federal revenues for that fiscal year, by an amount that is greater than the maximum deficit amount for such fiscal years as determined under section 601(a).

(d) Adjustments.—(1) Notwithstanding any other provision of law, concurrent resolutions on the budget for fiscal years 1992, 1993, 1994, and 1995 under section 301 or 304 may set forth levels consistent with allocations increased by—

(A) amounts not to exceed the budget authority amounts in section 251(b)(2)(E)(i) and (ii) of the Balanced Budget and Emergency Deficit Control Act of 1985 and the composite outlays per category consistent with them; and

(B) the budget authority and outlay amounts in section 251(b)(1) of that Act.

(2) For purposes of congressional consideration of provisions described in sections 251(b)(2)(A), 251(b)(2)(B), 251(b)(2)(C), 251(b)(2)(D), and 252(e), determinations under sections 302, 303, and 311 shall not take into account any new budget authority, new entitlement authority, outlays, receipts, or deficit effects in any fiscal year of those provisions.

SEC. 607. EFFECTIVE DATE.

This title shall take effect upon its date of enactment and shall apply to fiscal years 1991 and 1995.

Subtitle C—Social Security

SEC. 13301. OFF-BUDGET STATUS OF OASDI TRUST FUNDS.

(a) Exclusion of Social Security From All Budgets.—Notwithstanding any other provision of law, the receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund shall not be counted as new budget authority, outlays, receipts, or deficit or surplus for purposes of—

(1) the budget of the United States Government as submitted by the President,

(2) the congressional budget, or

(3) the Balanced Budget and Emergency Deficit Control Act of 1985.

(b) Exclusion of Social Security From Congressional Budget.—Section 301(a) of the Congressional Budget Act of 1974 is amended by adding at the end the following: "The concurrent resolution shall not include the outlays and revenue totals of the old age, survivors, and disability insurance program established under title II of the Social Security Act or the related provisions of the

Internal Revenue Code of 1986 in the surplus or deficit totals required by this subsection or in any other surplus or deficit totals required by this title.".

SEC. 13302. PROTECTION OF OASDI TRUST FUNDS IN THE HOUSE OF REPRESENTATIVES.

(A) In General.—It shall not be in order in the House of Representatives to consider any bill or joint resolution, as reported, or any amendment thereto or conference report thereon, if, upon enactment—

(1)(A) such legislation under consideration would provide for a net increase in OASDI benefits of at least 0.02 percent of the present value of future taxable payroll for the 75-year period utilized in the most recent annual report of the Board of Trustees provided pursuant to section 201(c)(2) of the Social Security Act, and (B) such legislation under consideration does not provide at least a net increase, for such 75-year period, in OASDI taxes of the amount by which the net increase in such benefits exceeds 0.02 percent of the present value of future taxable payroll for such 75-year period.

(2)(A) such legislation under consideration would provide for a net increase in OASDI benefits (for the 5-year estimating period for such legislation under consideration), (B) such net decrease, together with the net decreases in OASDI benefits resulting from previous legislation enacted during that fiscal year or any of the previous 4 fiscal years (as estimated at the time of enactment) which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, exceeds $250,000,000, and (C) such legislation under consideration does not provide at least a net increase, for the 5-year estimating period for such legislation under consideration, in OASDI taxes which, together with net increases in OASDI taxes resulting from such previous legislation which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, equals the amount by which the net increase derived under subparagraph (B) exceeds $250,000,000;

(3)(A) such legislation under consideration would provide for a net increase in OASDI taxes of at least 0.02 percent of the present value of future taxable payroll for the 75-year period utilized in the most recent annual report of the Board of Trustees provided pursuant to section 201(c)(2) of the Social Security Act, and (B) such legislation under consideration does not provide at least a net decrease, for such 75-year period, in OASDI taxes of the amount by which the net decrease in such benefits exceeds 0.02 percent of the present value of future taxable payroll for such 75-year period, or

(4)(A) such legislation under consideration would provide for a net decrease in OASDI benefits (for the 5-year estimating period for such legislation under consideration), (B) such net decrease, together with the net decreases in OASDI taxes resulting from previous legislation enacted during that fiscal year or any of the previous 4 fiscal years (as estimated at the time of enactment) which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, exceeds $250,000,000, and (C) such legislation under consideration does not provide at least a net decrease, for the 5-year estimating period for such legislation under consideration, in OASDI benefits which, together with net decreases in OASDI benefits resulting from such previous legislation which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, equals the amount by which the net decrease derived under subparagraph (B) exceeds $250,000,000.

(a) APPLICATION.—In applying paragraph (3) or (4) of subsection (a), any provision of any bill or joint resolution, as reported, or any amendment thereto, or conference report thereon, the effect of which is to provide for a net decrease for any period in taxes described in subsectiōn (c)(2)(A) shall be disregarded if such bill, joint resolution, amendment, or conference report also includes a provision the effect of which is to provide for a net increase of at least an equivalent amount for such period in medicare taxes.

(c) DEFINITIONS.—For purposes of this subsection:

(1) The term "OASDI benefits" means the benefits under the old-age, survivors, and disability insurance programs under title II of the Social Security Act.

(2) The term "OASDI taxes" means—

(A) the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1986, and

(B) the taxes imposed under chapter 1 of such Code (to the extent attributable to section 86 of such Code).

(3) The term "medicare taxes" means the taxes imposed under sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1986.

(4) The term "previous legislation" shall not include legislation enacted before fiscal year 1991.

(5) The term "5-year estimating period" means, with respect to any legislation, the fiscal year in which such legislation becomes or would become effective and the next 4 fiscal years.

(6) No provisions of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of OASDI taxes referred to in paragraph (2)(B) unless such provision changes the income tax treatment of OASDI benefits.

* * * * * * *

Subtitle E—Government-sponsored Enterprises

SEC. 13501. FINANCIAL SAFETY AND SOUNDNESS OF GOVERNMENT-SPONSORED ENTERPRISES.

(a) DEFINITION.—For purposes of this section, the terms "Government-sponsored enterprise" and "GSE" mean the Farm Credit System (including the Farm Credit Banks, Banks for Cooperatives, and Federal Agricultural Mortgage Corporation), the Federal Home Loan Bank System, the Federal Home Loan Mortgage Corporation, the Federal National Mortgage Association, and the Student Loan Marketing Association.

(b) TREASURY DEPARTMENT STUDY AND PROPOSED LEGISLATION.—

(1) The Department of the Treasury shall prepare and submit to Congress no later than April 30, 1991, a study of GSEs and recommended legislation.

(2) The study shall include an objective assessment of the financial soundness of GSEs, the adequacy of the existing regulatory structure for GSEs, the financial exposure of the Federal Government posed by GSEs, and the effects of GSE activities on Treasury borrowing.

(c) CONGRESSIONAL BUDGET OFFICE STUDY.—

(1) The Congressional Budget Office shall prepare and submit to Congress no later than April 30, 1991, a study of GSEs.

(2) The study shall include an analysis of the financial risks each GSE assumes, how Congress may improve its understanding of those risks, the supervision and regulation of GSEs' risk management, the financial exposure of the Federal Government posed by GSEs, and the effects of GSE activities on Treasury borrowing. The study shall also include an analysis of alternative models for oversight of GSEs and of the costs and benefits of each alternative model to the Government and to the markets and beneficiaries served by GSEs.

(d) ACCESS TO RELEVANT INFORMATION.—

(1) For the studies required by this section, each GSE shall provide full and prompt access to the Secretary of the Treasury and the Director of the Congressional Budget Office of its books and records and other information requested by the Secretary of the Treasury or the Director of the Congressional Budget Office.

(2) In preparing the studies required by this section, the Secretary of the Treasury and the Director of the Congressional Budget Office may request information from, or the assistance of, any Federal department or agency authorized by law to supervise the activities of a GSE.

(e) CONFIDENTIALITY OF RELEVANT INFORMATION.—

(1) The Secretary of the Treasury and the Director of the Congressional Budget Office shall determine and maintain the confidentiality of any book, record, or information made available by a GSE under this section in a manner consistent with the level of confidentiality established for the material by the GSE involved.

(2) The Department of the Treasury shall be exempt from section 552 of title 5, United States Code, for any book, record, or information made available under subsection (d) and determined by the Secretary of the Treasury to be confidential under this subsection.

(3) Any officer of employee of the Department of the Treasury shall be subject to the penalties set forth in section 1906 of title 18, United States Code, if—

(A) by virtue of his or her employment or official position, he or she has possession of or access to any book, record, or information made available under and determined to be confidential under this section; and

(B) he or she discloses the material in any manner other than—

(i) to an officer or employee of the Department of the Treasury; or

(ii) pursuant to the exception set forth in such section 1906.

(4) The Congressional Budget Office shall be exempt from section 203 of the Congressional Budget Act of 1974 with respect to any book, record, or information made available under this subsection and determined by the Director to be confidential under paragraph (1).

(f) REQUIREMENT TO REPORT LEGISLATION.—(1) the committees of jurisdiction in the House shall prepare and report to the House no later than September 15, 1991, legislation to ensure the financial soundness of GSEs and to minimize the possibility that a GSE might require future assistance from the Government.

(2) It is the sense of the Senate that the committees of jurisdiction in the Senate shall prepare and report to the Senate no later than September 15, 1991, legislation to ensure the financial safety and soundness of GSEs and to minimize the possibility that a GSE might require future assistance from the Government.

(f)[11] PRESIDENT'S BUDGET.—The President's annual budget submission shall include an analysis of the financial condition of the GSEs and the financial exposure of the Government, if any, posed by GSEs.

---

[11] So in law. Probably should be redesignated as "(g)".

APPENDIX R. COMMITTEE ON WAYS AND MEANS MARCH 1991 REPORT TO THE BUDGET COMMITTEE

Committee on Ways and Means,
U.S. House of Representatives,
Washington, DC, March 12, 1991.

Hon. Leon E. Panetta,
Chairman, Committee on the Budget,
U.S. House of Representatives, Washington, DC.

Dear Mr. Chairman: As required by section 301(d) of the Congressional Budget Act of 1974, this letter transmits the views and estimates of the Committee on Ways and Means on those aspects of the Federal budget for fiscal year 1992 which fall within the Committee's jurisdiction.

In making this report, the Committee on Ways and Means wishes to express its concern about national economic conditions in fiscal year 1992 and beyond. Although the United States and its allies have successfully concluded military operations in the Persian Gulf War, the country still faces political uncertainties in the Middle East while simultaneously facing a recession at home. The unknown future of foreign policy plus mixed signals from recent economic indicators make forecasting the length and depth of the economic downturn very uncertain. As a result of the slowed economy, unemployment is on the rise and real wage growth, particularly among males, has become stagnant. The United States is also plagued by a huge budget deficit and a large but declining trade deficit. In addition, the country continues to be a debtor nation for the seventh consecutive year. Millions of Americans lack access to quality health care while many have no access at all. In addition, although we have made progress over the past six years, child poverty rates remain at unacceptably high levels.

To increase the effectiveness and efficiency of government, the Committee on Ways and Means intends to vigorously pursue an oversight agenda for all programs within the Committee's jurisdiction. Moreover, the Committee will examine long-term strategies on such important issues as international competitiveness, health insurance coverage and costs, and children.

I. The Need for Stability.—Last year, the Administration and the Congress enacted a major deficit reduction bill and legislated significant changes in the budget process. Over the last nine years, five major, and several smaller, revenue bills were enacted which dramatically changed the Federal tax structure for both individuals and corporations. In addition, major changes have been enacted, significantly affecting Medicare providers and beneficiaries. Given the scope and pace of these changes, the Committee feels strongly that stability in the Federal Tax Code, as well as in Medicare, is essential. No other program has faced more legislative changes than Medicare. The Committee believes it is prudent that the budget process not force another series of legislative changes in either the Medicare program or the tax structure.

II. No Reconciliation.—Since the duration and scope of our continued involvement in the Persian Gulf and the depth and duration of the recession are both uncertain at this time, the Committee strongly insists, on both a bipartisan and unanimous basis, that there be no reconciliation directive to the Committee on either revenues or outlays.

III. The President's Budget Proposals.—The Committee recognizes that the President's Budget contains several revenue proposals, some of which increase and some of which decrease taxes. In addition, the President has proposed legislative reductions of $25 billion in Medicare over the next five years, a cap on foster care administrative funds under Title IV-E of the Social Security Act and the complete repeal of the Trade Adjustment Assistance program (TAA). The Committee anticipates little or no budgetary savings this fiscal year from these proposals.

IV. Possible Committee Initiatives.—At some time during the year, the Committee may consider the following initiatives with budgetary consequences: tax simplification, expiring tax provisions, preventive and other health measures, unemployment insurance reforms and improvements, child welfare changes, and other measures. The Committee will fully comply with the new pay-as-you-go requirements, as we have in previous years. However, given the uncertainty of economic projections at this time, the Committee wishes to emphasize that the budget resolution should not attempt to project the amount of outlays or revenue losses associated with the above initiatives. Instead, the Budget Committee should be assured that all legislation reported from the Committee on Ways and Means will be deficit neutral, consistent with the new pay-as-you-go requirements.

V. Other Budget Issues.—Throughout the year, the Committee will monitor the cost of Operation Desert Storm and, to the maximum extent possible, assist the Administration in its efforts to ensure that our Allies pay their fair share of the costs. Also, the Committee will monitor the implementation of the budget summit as it applies to government-sponsored enterprises and the cost of the savings and loan bailout.

VI. Administrative Funding.—Additionally, the Committee wishes to express its concern with the administration of all programs within our jurisdiction. While the amount of administrative funding for these agencies is within the jurisdiction of the Committee on Appropriations, we are seriously concerned that the budget process not further restrict the ability of the Appropriations Committee to provide sufficient resources for these agencies so that they may perform their functions on behalf of millions of Americans. In particular, we are concerned about funding levels for the Internal Revenue Service, the Social Security program, the Medicare program, the Unemployment Compensation program, the Office of the U.S. Trade Representative, the U.S. Customs Service, and the Bureau of Alcohol, Tobacco and Firearms.

VII. Public Debt Limit.—The present statutory limit is $4,145 billion, a level that the Committee projects will be sufficient through the end of fiscal year 1993. Thus, legislative action will not be required on the public debt limit this year.

VIII. Additional materials.—In keeping with our tradition of assisting the Budget Committee in carrying out its responsibilities and in making assessments concerning specific recommendations within the jurisdiction of the Committee on Ways and Means, I will forward, at a later date, a copy of a Ways and Means Committee print entitled, "Background Materials and Data on Programs Within the Jurisdiction of the Committee on Ways and Means—1991 edition." This document will include a description of the Administration's fiscal year 1992 budget recommendations under the jurisdiction of the Committee on Ways and Means.

I hope you will find these views and recommendations of the Committee on Ways and Means useful. As always, I am available to answer any questions you or any other Members of your Committee may have on any aspect of this report.

With warm regards, I am

Sincerely yours,

DAN ROSTENKOWSKI, *Chairman.*

○

[ERRATA]

102D CONGRESS
1st Session

COMMITTEE PRINT

WMCP:
102-9

See Reverse Side for Corrections

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

OVERVIEW OF ENTITLEMENT PROGRAMS

1991 GREEN BOOK

BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

MAY 7, 1991

Prepared for the use of Members of the Committee on Ways and Means by members of its staff. This document has not been officially approved by the Committee and may not reflect the views of its Members

U.S. GOVERNMENT PRINTING OFFICE
39-759
42-911
WASHINGTON : 1991

H782-12

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

[ERRATA]

Page 899—(table 17)—the last figure (ending income) for the year 1993 should be 20,621

Page 967—the chart should have the following head:

CHART 5. BIRTH RATE, ABORTION RATE, AND PREGNANCY RATE PER 1,000 WOMEN AGED 15–19, 1972–85

Page 968—the chart should have the following head:

CHART 6. BIRTH RATE, ABORTION RATE, AND PREGNANCY RATE PER 1,000 WOMEN AGED 15–19, 11 COUNTRIES, 1983

Page 1075—the last figure in the table (percent change 1972-90 in AFDC benefits) should be a negative number: −35.7

Page 1162—the chart head should be:

CHART 3. EFFECTS OF MEANS-TESTED PROGRAMS AND TAXES ON INDIVIDUALS IN POVERTY, 1979–1989

Page 1165—the table head on page 1166 should be repeated on page 1165

Page 1169—the table head on page 1170 (but not the word "Continued") should be repeated on page 1169

Page 1312—the number −46.1 should be 46.1 (a positive number) in the line "96 to 99 percent" reading across to the 6th column (change in 1992 income relative to 1977)

Page 1514—in the second panel of table 6, the row reading across from "Medicaid" should be: 28.3 12.8 38.0 46.1

Page 1545—

The first sentence of footnote 2 should read: "The average dollar change in income is the sum of the average tax increase (or decrease) plus the average entitlement decrease (or increase) per family."

The second paragraph of the note should read: "Revenue provisions: Capital gains; hospital insurance coverage to State and local employees; extension of the research and experimentation credit; family savings account."